State of California
Child Fatality and Near Fatality
Five-Year Report: 2010-2014

Prepared by the California Department of Social Services,
Children's Services Operations Bureau – February 2019

CDSS
CALIFORNIA
DEPARTMENT OF
SOCIAL SERVICES

State of California
Child Fatality and Near Fatality
Five-Year Report
2010-2014

Table of Contents

Executive Summary

This report focuses on the 1,151 child fatalities and near fatalities that were reported to the California Department of Social Services (CDSS) between 2010 and 2014. The report reflects CDSS' continued commitment to providing information and data to inform our understanding of these tragic incidents, the victims and the families involved, and the systemic issues and trends which can be addressed at a statewide policy level.

Trends identified in the report include:

- Children under age one experienced the largest concentration of fatalities and near fatalities, accounting for nearly half (48.8 percent) all such incidents.

- Blunt Force Trauma and Abusive Head Trauma account for over half (52 percent) of all fatalities and near fatalities.

- Male caregivers are the most common perpetrator of physical abuse-related fatalities and near fatalities such as blunt force trauma and abusive head trauma (previously referred to as Shaken Baby Syndrome), responsible for nearly two-thirds of all such fatalities and near fatalities.

- Nearly two-thirds of child fatality and near fatality incidents between 2010 and 2014 involved families who had some form of prior contact with a child welfare services (CWS) agency.

- Proven child abuse prevention methods and community resources should be made available to a multitude of caregivers without age restrictions.

It is our hope that members of the public, researchers, policy makers, and others find the information in this report useful in developing solutions aimed at mitigating the incidence of future maltreatment related fatalities and near fatalities in children. CDSS continues to develop collective strategies for preventing these fatalities and near fatalities, including the recommendations presented in this report.

The number of child abuse and neglect fatality incidents reported to CDSS is small when compared to the overall child welfare population and the statewide child population. In addition to percentages and raw numbers, this report presents rates to control for fluctuations in the statewide child population and allow for comparisons over time and between groups. Individuals who read this report are cautioned against generalizing the data to child welfare cases overall.

This report, as well as prior years' California Annual Child Fatality and Near Fatality Reports, can be found at http://www.cdss.ca.gov/inforesources/Information-Resources/Program-and-Legislative-Reports. Questions regarding the report can be directed to CFSDCriticalIncident @dss.ca.gov or (916) 651-8100.

Recommendations and Strategies

Each act of fatal and near fatal child abuse and neglect represents a life cut short or irrevocably altered. The following recommendations and strategies, if implemented, could help prevent child abuse and neglect fatalities and near fatalities in California. The strategies are activities CDSS commits to implement or explore, and the recommendations are suggestions to CDSS partners and stakeholders based on information gathered from the analysis of child fatality and near fatality incidents.

Reduce Risk to Infants and Young Children

In California more than 80 percent of child fatalities and near fatalities due to abuse or neglect occur in children younger than five years of age, and nearly half of all fatalities and near fatalities occur in children under age one. Newborns are especially vulnerable. To address this issue, CDSS has identified several opportunities for growth to human services in the community.

Recommendations

Support the expansion of evidence-based home visiting programs

Home visiting is a voluntary program that pairs pregnant and newly parenting women with a nurse or trained professional who makes regular visits in the participant's home to provide guidance, coaching, and access to health and social services. The goal is to assist participants in having a healthy pregnancy and delivery, and to ensure they have the tools necessary to prepare for their parental role.[1] The program gives children a solid start and strengthens families and communities.

Evidence-based home visiting programs have been demonstrated to reduce abuse and neglect.[2] Expanded use of home visiting programs is a promising practice to provide parents with support and skills to nurture their children.

Strongly encourage all mandated reporters receive training on a regular basis

While statute designates 44 categories of professions as mandated reporters, most of these individuals are not required by law to participate in training on identifying child behaviors, injuries, or statements that are indicative of abuse or neglect. While many mandated reporters do receive training from their employer, there are few guidelines that dictate training frequency or identify recommended training content to ensure staff are

[1] California Department of Public Health. (2017, April 12). What is home visiting? HomeStory, Electronic newsletter.

[2] Commission to Eliminate Child Abuse and Neglect Fatalities. (2016). Within our reach: A national strategy to eliminate child abuse and neglect fatalities. Washington, DC: Government Printing Office. Retrieved from http://www.acf.hhs.gov/programs/cb/resource/cecanf-final-report

and remain informed of child abuse identification, trends and changes in reporting laws. Mandated reporters who do not receive consistent training may overlook signs of abuse and/or neglect in the children with whom they are working.

Research demonstrates that trained reporters are more likely to report abuse than those who have not received training.[3] Encouraging each mandated reporter to complete a state-approved training on a regular basis would support the effectiveness of the mandated reporting law and may improve child safety if reporters are more aware of which suspicions to report.

CDSS Strategies

Prioritize cases involving at-risk newborns and infants for investigation if referred to a child welfare services agency

In recognition of the extreme vulnerability of young children, the federal Commission to Eliminate Child Abuse and Neglect Fatalities (CECANF) recommended that states develop policies requiring that referrals alleging abuse or neglect to a child under age three and repeat referrals on the same child be prioritized for investigation.

Increase Outreach to Male Caregivers

Male caregivers alone or in conjunction with a partner were the most common perpetrator of violent deaths and near fatalities among children. Increasing and strengthening outreach and prevention efforts within the community is crucial to spread the message about the dangers of shaking or striking an infant or very young child and the identification of crisis prevention resources available to all caregivers.

Recommendations

Ensure that male caregivers are assessed for services, when appropriate

Case reviews revealed that male caregivers, such as biological fathers, stepfathers or mother's significant others, are often not assessed for services. Counties should review policies and procedures to ensure comprehensive assessment of a child's home, including all caregivers in a child's life. Although these caregivers may not be legally entitled to services, counties should assess whether a referral to voluntary services within the community is appropriate as best practice. When creating case plans, safety plans or to determine if a child can safely remain in the home, counties should consider working with community agencies to offer voluntary services to other caregivers, as appropriate, in order to, maintain the safety of the child and stability of the family.

[3] Sedlak, A. M. (2010). Fourth National Incidence Study of Child Abuse and Neglect (NIS–4): Report to Congress. Washington, DC: U.S. Department of Health and Human Services, Administration for Children and Families. Retrieved from http://www.acf.hhs.gov/programs/opre/abuse_neglect/natl_incid/index.html

CDSS Strategies

Increase child abuse prevention outreach to male caregivers and conduct outreach and awareness for mothers about warning signs of a dangerous or unfit caregiver

CDSS has begun discussions with other state departments to identify partnership strategies to develop public awareness messages for positive parenting. One possible option is the creation of a public service announcement message and video that could be played in office waiting rooms and while individuals are on hold when making phone calls regarding their state services. Proven child abuse prevention methods and community resources should be made available to a multitude of caregivers without age restrictions.

Information regarding criteria on how to choose a safe care provider has been included in new AHT brochure, available here: http://www.cdss.ca.gov/inforesources/OCAP/Shaken-Baby-Syndrome

Improve outreach to mothers before birth and immediately following birth by outreach through obstetricians and pediatricians.

Most expecting mothers in California receive at least some prenatal care,[4] and nearly all mothers deliver their children in a hospital. As trusted medical providers, Obstetrician/Gynecologists (OB/GYNs) and pediatricians are in an excellent position to raise awareness about the dangers of shaking a baby and identify the warning signs that a partner may not be safe to be with her child. OB/GYNs and pediatricians can also inquire routinely about domestic violence, which is very highly correlated with child abuse. CDSS will work with the Healthcare Advisory Group (HAG), a workgroup consisting of representatives from healthcare provider groups across the state, to develop and disseminate information to provide to OB/GYNs and pediatricians statewide.

Children who are in open or recently closed investigations or cases

Thirty-four percent of critical incidents, which are defined as fatalities and near fatalities combined, occur among families who are currently in a child welfare services investigation or case or who have been reported to child welfare services within the previous year. These tragedies occur despite an assessment, investigation or regular visitation by a case-carrying social worker. CDSS has identified the following strategies to help strengthen investigations and services to families referred to child welfare.

[4] Kidsdata.org (2017c, July 19). Infants whose mother received prenatal care in the first trimester, 2013. Retrieved July 19, 2017 from Kidsdata.org: http://www.kidsdata.org/topic/59/prenatal-care/summary

Recommendations

Improve Social Work Practice by ensuring staff training and delivered services

Nearly two-thirds (63.2 percent) of families who experience a child fatality or near fatality have been in contact with child welfare at some point in the past and 34 percent have been in contact within one year. County child welfare agencies and Boards of Supervisors are urged to promote strong social work practices by ensuring that staff and supervisors have the tools they need to succeed, including adequate support, coaching, and ongoing training. Adequate training and coaching in Structured Decision Making (SDM) and other assessment techniques also ensures rigorous and effective social work. Continued funding and support for services such as mental health, substance abuse treatment and housing is vital to create strong families and keep children safe.

CDSS Strategies

Improve statewide social worker training and education

CDSS implemented the curriculum for CORE 3.0, a mandatory training course for all new social workers in California. CORE 3.0 offers a far more dynamic learning experience than previous CORE classes, including the opportunity to role-play scenarios and work with a field advisor while training. CORE 3.0 places an increased emphasis on interviewing and appropriate use of the SDM assessment tools. In addition, CORE 3.0 is developing advanced classes that will be available to all social workers and will meet the requirements for continuing education. One of the classes will focus on techniques for successfully interviewing children, including very young children.

Improve hotline screening decisions statewide

Review-Evaluate-Direct (RED) teams are used in some counties as a way for social work teams to meet and collaboratively discuss and determine if a hotline call should be investigated and how quickly the investigation should take place. This system acts as a secondary review to ensure the most appropriate response determination is selected during the intake process. CDSS will study the impacts of RED teams and provide guidance on best practices with this or other team staffing methods. Additionally, in 2019 some counties may begin piloting the use of a predictive risk model to further inform RED team discussions about response decisions.

Improve the Use of Risk and Safety Assessments

CDSS released guidance through All County Letter 17-107 which reminds counties about the use of SDM Safety and Risk Assessments to ensure child safety during investigations and throughout a case. The letter also identified how to develop an effective safety plan and identify criteria to create measurable goals that can be appropriately monitored.

2010-2014 Combined Fatalities and Near Fatalities

The relatively small number of fatalities or near fatalities (collectively referred to as critical incidents) in any given year poses a challenge in terms of data analysis and identifying trends. In an effort to provide more robust analysis than can be derived from a single year's data, CDSS staff analyzed a data set of 1,151 child fatalities and near fatalities that occurred between 2010 and 2014 and were reported to and reviewed by CDSS.

The 1,151 cases analyzed in this report include all cases reported to CDSS where a child suffered a fatality or near fatality at the hands of a parent, guardian, family member, caregiver or household member, or cases where a child suffered a fatality or near fatality at the hands of another person and the parent or guardian was found to be neglectful. (For the purposes of this report, a parent's significant other is considered as a "household member" even if he or she did not reside in the same house as the child victim).

Throughout the analysis, CDSS found that the distribution of age, gender, ethnicity, perpetrator relationship, and previous child welfare history was extremely similar when child fatalities and near fatalities were compared. This supports the theory that fatality and near fatality incidents are largely similar and the only significant difference between a child fatality and a child near fatality is the degree of force used, rapidity and effectiveness of medical treatment, and some degree of chance. As such, the two data sets are presented together to show their combined numbers and analysis. Prevention recommendations address both child fatalities and near fatalities.

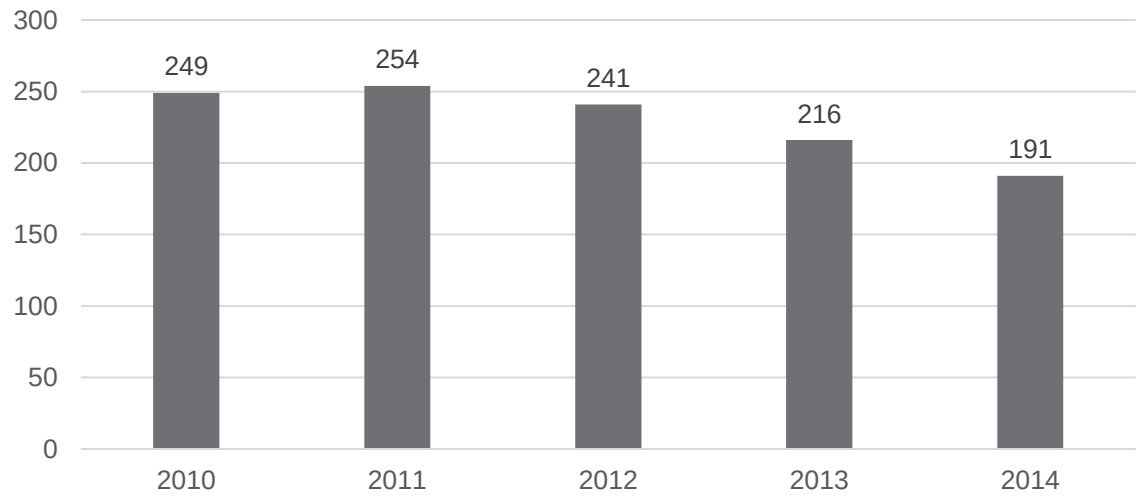
Overall, the findings reflect trends that have been reported in previously issued Child Fatality and Near Fatality Reports by CDSS, which can be found here: http://www.cdss.ca.gov/inforesources/Information-Resources/Program-and-Legislative-Reports. Identified trends that remain consistent are the disproportionate fatality and near fatality rates of young infants as well as Black and Multi-Racial children, when compared to other ages and ethnicities and their associated proportion of the overall child population in California.

Overview

The number of critical incidents has slightly declined since 2011, a pattern that is seen in both fatalities and near fatalities (Figure 1). The statewide child fatality rate was 0.97 fatalities per 100,000 children in 2014. This is below the national child fatality rate of 2.13 fatalities per 100,000 children reported in the 2014 Child Maltreatment Report [5],[6]. The statewide rate over the five-year period from 2010-2014 was 1.2 per 100,000 for child fatalities and 1.3 per 100,000 for child near fatalities, for a combined rate of 2.5 critical incidents for every 100,000 children over the five-year period.[7]

The critical incident rate for children under age five has declined over the past five years and is largely responsible for the overall trend of decreasing child fatalities and near fatalities.[8] Critical incident rates among older children have remained steady or have declined only slightly.
It should be noted; the identification of trends remains difficult due to the small number of critical incidents for children ages five and older.

FIGURE 1
2010-2014 Total Combined Critical Incidents



[5] U.S. Department of Health & Human Services. (2016a).
[6] National data is not available for child near fatalities.
[7] Appendix Tables XV
[8] Appendix Tables XV

FIGURE 2
Five Year Combined (2010-2014) Child Critical Incidents,
Child Population (0-17) and Rate per 100,000

	Critical Incidents		Child Population		Rate per 100,000
	n	%	n	%	
Total	**1,151**	**100.0**	**45,829,424**	**100.0**	**2.5**
Age Group					
<1 Yr. Old	562	48.8	2,495,635	5.4	22.5
1-4 Yrs. Old	392	34.1	10,039,446	21.9	3.9
5-9 Yrs. Old	101	8.8	12,603,646	27.5	0.8
10-14 Yrs. Old	64	5.6	12,696,694	27.7	0.5
15-17 Yrs. Old	32	2.8	7,994,003	17.4	0.4
Sex					
Female	486	42.2	22,403,917	48.9	2.2
Male	665	57.8	23,425,507	51.1	2.8
Race/Ethnicity*					
Black	226	20.9	2,529,012	5.5	8.9
Hispanic	460	42.5	23,513,138	51.3	2.0
White	268	24.9	12,544,069	27.4	2.1
Asian/P.I.	36	3.3	5,033,370	11.0	0.7
Nat American	6	0.6	182,151	0.4	3.3
Multi-Race**	85	7.9	2,027,684	4.4	4.2

** 70 children with Other or Not Documented or Missing Race/Ethnicity are excluded from n and % calculations in the Race/Ethnicity section.*

*** Multi-Race category was not available in 2010.*

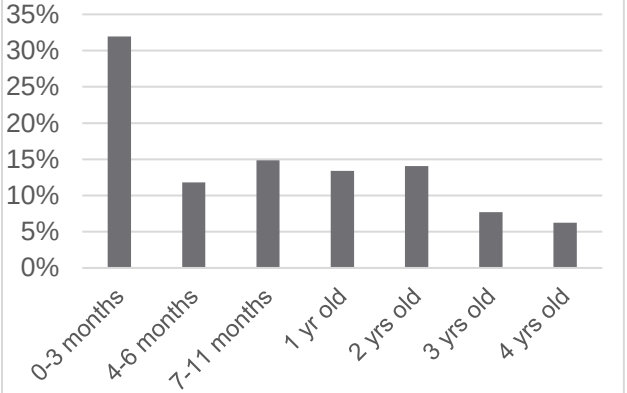
Victim Age

Infants, defined as children under age one, were the victims in approximately half (48.8 percent) of all critical incidents reported to CDSS between 2010 and 2014. Children ages one to four comprised one-third (34.1 percent) of all critical incidents, while children ages five and older represented 17.1 percent of all fatality and near fatality victims. The distribution of ages between child fatality and child near fatality victims was nearly identical.[9]

Children under age one suffer fatalities and near fatalities at disproportionate rates compared to children from other age groups. Over the five-year period, the fatality rate for children under age one was 9.9 per 100,000, and the near fatality rate was 12.7 per 100,000. By comparison, the fatality rate for children ages one to four was 1.9 per 100,000 and the near fatality rate was 2.0 per 100,000.[10].[11] The higher incidence of near fatalities compared to fatalities in infants is seen to a lesser extent in children ages one to four, but not in other age groups. Infants, due to their vulnerability, are more likely to be placed in critical care for lesser injuries than older children following a critical incident.

Critical incident risk is highest among the very youngest children. Thirty-two percent of all fatalities and near fatalities among children ages zero to four years occurred within three months of birth (Figure 3).[12] Among all children ages zero to four years old, blunt force trauma and abusive head trauma were the leading causes of critical incidents.[13] Children ages four to six months accounted for 12 percent and those ages 7-11 months accounted for 15 percent of all critical incidents. Sleep related deaths were the second most common cause for children ages zero to six months.

FIGURE 3
2011-2014 Critical Incidents by Age 0-4
(n=754)*



For children ages six months to two years, drowning was the second most common cause after physical abuse. Vehicular negligence and medical neglect were the leading causes of fatality and near fatality incidents for children ages 5 to 17, but overall, critical incidents in these age groups were too statistically small for meaningful analysis.[14]

[9] Appendix Tables II and IX
[10] Under age 1- Fatality Rate ((246/2,495,635) *100,000=9.9), Near Fatality Rate ((316/2,495,635) *100,000=12.7). Age 1-4 – Fatality Rate ((191/10,039,446) *100,000=1.9), Near Fatality Rate ((201/10,039,446) *100,000=2.0).
[11] Appendix Tables I and VIII
[12] N equals number of children between 0 months and 4 years old who suffered a critical incident between 2011 and 2014. Detailed age data was not available for 2010.
[13] Appendix Table IV and XI
[14] Appendix Tables IV and XI

Data Highlight: Children ages 0-3 months

Between 2011 and 2014, 241 infants between the ages of zero and three months suffered fatal or nearly fatal abuse and neglect. Figure 4 illustrates that the demographic characteristics of infants who experienced a critical incident were similar to the larger child fatality and near fatality populations.

FIGURE 4

2011-2014
Critical Incident Demographics Characteristic Distributions for Children Ages 0-3 Mo. (n=241) and 0-18 Yrs. Old (n=854)

	0-3 Mo.	0-18 Yrs.
Male	53.9%	58.6%
Female	46.0%	41.3%
Black	17.6%	19.7%
Hispanic	38.0%	42.6%
White	26.9%	23.6%
Asian/Pacific Islander	2.6%	3.3%
Native American	0.8%	0.5%
Multi-Racial	13.7%	9.9%

Of the 241 cases, 218 were analyzed.[15] As with all critical incidents, newborns and young infants were most likely to suffer a critical incident resulting from blunt force trauma or abusive head trauma, which together accounted for 54 percent of all critical incidents in this age group. The next most common cause of a critical incident was sleep-related fatalities, which claimed the lives of 24 infants, and medical neglect, which was responsible for 19 fatalities and near fatalities.

Newborns were just as likely to be in a family known to child welfare as other children. Overall, approximately one third of children (32.2 percent) ages zero to three months were from families who were reported to child welfare at some point in the prior year, nearly identical to the average of 34 percent of all age groups who were known to child welfare within a year of the fatal or near fatal incident.[16]

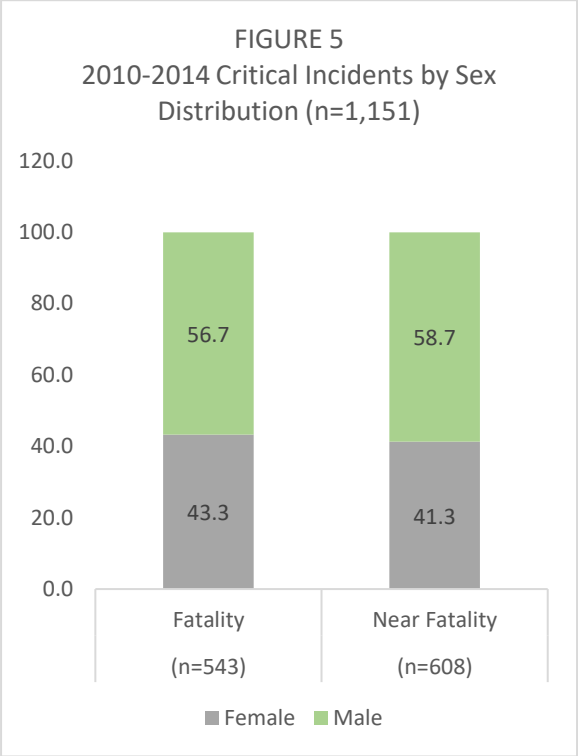
In all critical incidents, including those among infants, the biological father alone or in conjunction with the mother was responsible for the majority of blunt force trauma or abusive head trauma deaths (Figure 8).

These findings highlight the importance of ensuring caregivers are cognizant of the dangers caused by shaking or striking infants or young children and are aware of crisis prevention resources available within their community.

[15] See note in Methodology beginning on page 14 regarding near fatalities that were not analyzed in 2013.
[16] Appendix Tables VI and XIII

Victim Sex

Over the five-year period from 2010 to 2014, males were slightly more likely than females to suffer a critical incident. In all, males accounted for 57.8 percent of all critical incidents and females accounted for 42.2 percent, a finding which did not differ when fatalities and near fatalities were considered separately (Figure 5).[17] This disparity is consistent over time and reflective of findings at the national level.[18]



Some of the possible reasons for the disparity between males and females in child maltreatment deaths were discussed in the 2014 Child Fatality Report.[19] Proposed reasons included boys' greater vulnerability to sleep-related incidents in infancy and greater overall risk-taking due to lack of supervision starting in the preschool years and throughout adolescence accounting for greater rates of accidental neglect-related critical incidents.

Victim Race/Ethnicity

Of the 1,151 critical incidents that occurred between 2010 and 2014, race/ethnicity data was recorded for 1,081 child victims. Of these, 226 (20.9 percent) were Black, 460 (42.5 percent) were Hispanic, 268 (24.9 percent) were White, 36 (3.3 percent) were Asian/Pacific Islander, 6 (0.6 percent) were Native American, and 85 (7.9 percent) were Multi-Race. Seventy victims did not have race or ethnicity information recorded.

Racial Disparity in Critical Incidents

As shown in Figures 2 and 6, between 2010 and 2014, Black children comprised on average 5.5 percent of the child population statewide but 20 percent of fatalities and near fatalities for which race/ethnicity data was recorded.

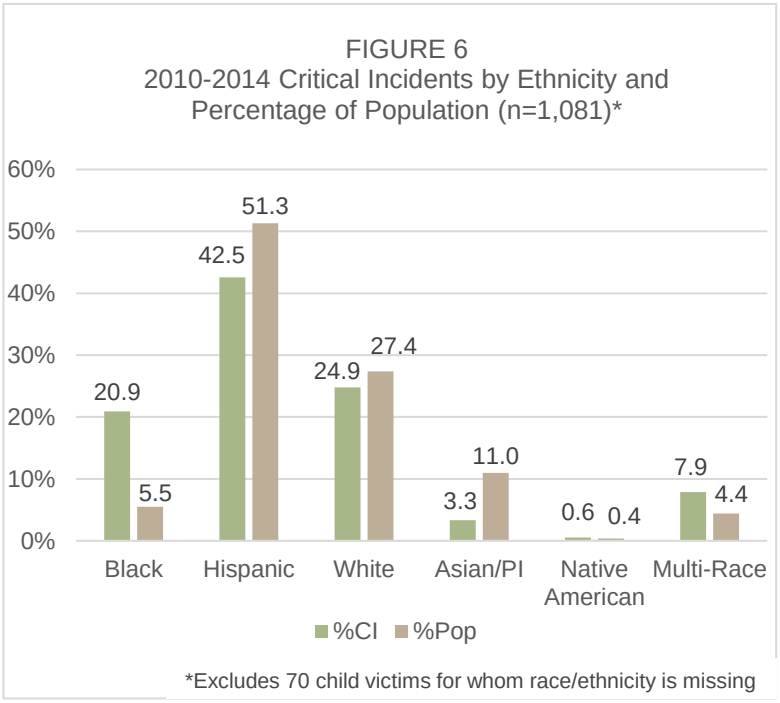
Conversely, White, Hispanic and Asian/Pacific Islander (API) children accounted for a smaller proportion of maltreatment-related critical incidents for which race/ethnicity data was recorded, as compared to their proportion of the statewide child population. Disproportionality was also

[17] Appendix Tables II and IX
[18] U.S. Department of Health & Human Services, Administration for Children and Families, Administration on Children, Youth and Families, Children's Bureau. (2016). Child maltreatment 2014. Washington, DC: Administration for Children and Families. Retrieved from http://www.acf.hhs.gov/programs/cb/research-data-technology/statistics-research/child-maltreatment
[19] California Department of Social Services. (2017). State of California child fatality annual report - calendar year 2014. Retrieved from http://www.cdss.ca.gov/inforesources/Child-Fatality-and-Near-Fatality/Data-and-Reports

observed among Multi-Race children; however, the data for this population is too small to be meaningfully analyzed.

Over time, racial disparities that have been noted in the broader child welfare system have also been evidenced in child fatalities and near fatalities. The relationship between race and child maltreatment was examined in a supplementary report on race differences produced by the federal Administration of Children and Families after the release of data in the National Incidence Study of Child Abuse and Neglect (NIS-4).[20]

The NIS-4 report examined rates of maltreatment by race in combination with various known risk factors. By conducting a sophisticated statistical analysis, the authors were able to demonstrate that the most accurate predictors of children's risk for abuse and neglect are characteristics that are correlated with race, rather than race *per se.* The risk factors examined included:



- Socioeconomic status
- Parental employment status
- Family structure (whether the child lived with married biological parents, unmarried biological parents, a single parent, a parent with an unrelated partner, or other family structure).
- Child age
- Number of children in the home (1, 2, 3, or 4+ children in the home)

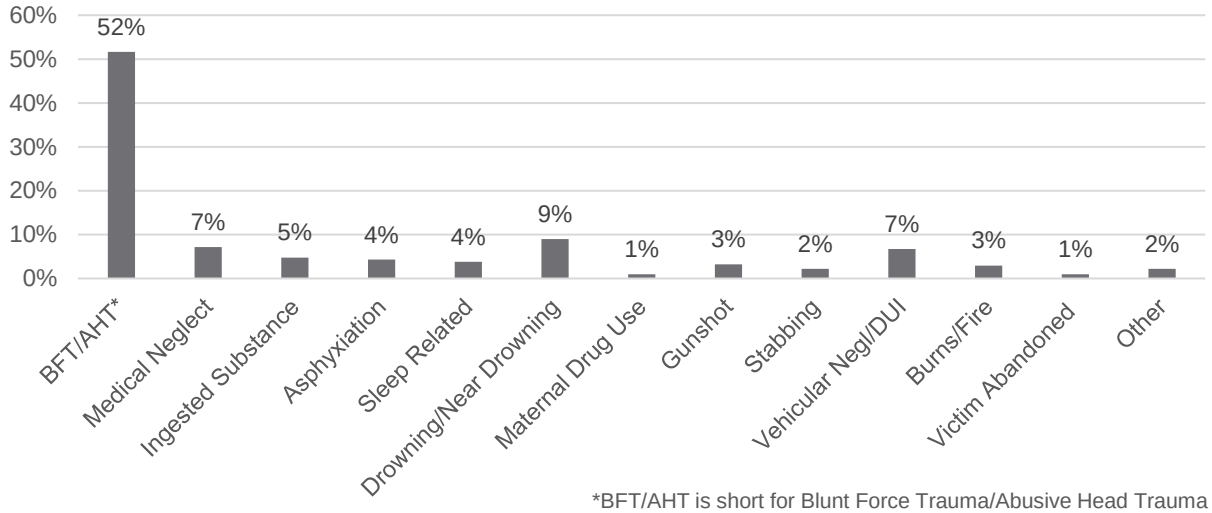
The report concludes that socioeconomic status, family structure, and number and ages of the children in the home are far more powerful influencers of child maltreatment than is race. In short, children who live in poverty are at a greater risk of child abuse and neglect, regardless of race. From the perspective of policy, the findings of the NIS-4 report highlight the need to address the underlying causes of child abuse and neglect, particularly poverty and its attendant stressors. Programs that reduce the number of children living in poverty and provide greater support to parents also reduce child abuse and neglect at all levels.

[20] Sedlak, A. M. (2010). Supplementary analyses of race differences in child maltreatment rates in the NIS-4. Washington, DC: Administration for Children and Families.

Cause of Critical Incident

Consistent with data found in previous reports, the most common causes of fatalities and near fatalities were blunt force trauma and abusive head trauma. Few differences in cause are found between fatalities and near fatalities, with the exception that abusive head trauma is more likely to result in a near fatality, while blunt force trauma is more likely to result in a fatality[21]. Due to inconsistency in how data regarding blunt force trauma and abusive head trauma data were collected over the years, they are presented as a combined cause of incident in the following analysis.

FIGURE 7
2010-2014 Critical Incident Causes (n=1,045)*



*BFT/AHT is short for Blunt Force Trauma/Abusive Head Trauma

Previous child fatality reports[22] have indicated that more children die of neglect than abuse. When fatality and near fatality data over a five-year period is examined, incidents involving physical abuse comprise more than half of all critical incidents (Figure 7).[23] The discrepancy may be due to substantiated neglect allegations by child welfare for parents that fail to protect their child from being physically abused while law enforcement investigates the perpetrator responsible for the physical abuse. As a result, a fatality or near fatality from blunt force trauma or abusive head trauma may be associated with a neglect allegation. However, when the actual cause of the incident, rather than the allegation is examined, it is apparent that physical abuse fatalities and near fatalities were slightly more common than fatalities and near fatalities that were the result of neglect.

[21] Appendix Tables IV and XI
[22] California Department of Social Services (2015). California child fatality annual report calendar years 2012 / 2013. Retrieved from http://www.cdss.ca.gov/inforesources/Child-Fatality-and-Near-Fatality/Data-and-Reports
[23] Excludes 106 cases where cause of death was unknown.

Race/Ethnicity and Cause of Critical Incident

Between 2010 and 2014, there was no significant difference in the causes of critical incidents among different racial/ethnic groups. This stands in contrast to the 2014 Child Fatality Report, which found that Black children were more likely to be the victim of physical abuse related deaths, while White and Hispanic children were more likely to suffer a fatality related to neglect.[24] However, when the aggregated data set is considered, this difference is no longer observed[25]. In all racial groups, with the exception of Native Americans, the combination of blunt force trauma and abusive head trauma accounted for between 39 and 46 percent of all critical incidents, and drowning accounted for between 12 and 17 percent of all critical incidents. Native Americans and Asian/Pacific Islander children experienced asphyxiation in higher proportions than other groups, but the very small numbers of these populations make it difficult to determine whether this is a trend.

Perpetrator

Biological parents alone or together accounted for 77.1 percent of the perpetrators of fatal or near fatal child abuse and neglect (Figure 8).[26] In situations where there were two individuals responsible for the critical incident, both of the individuals participated in the abuse, both were equally complicit in the neglect, or one parent or caregiver abused the child while the other caregiver knew or reasonably should have known about the abuse and failed to protect the child.

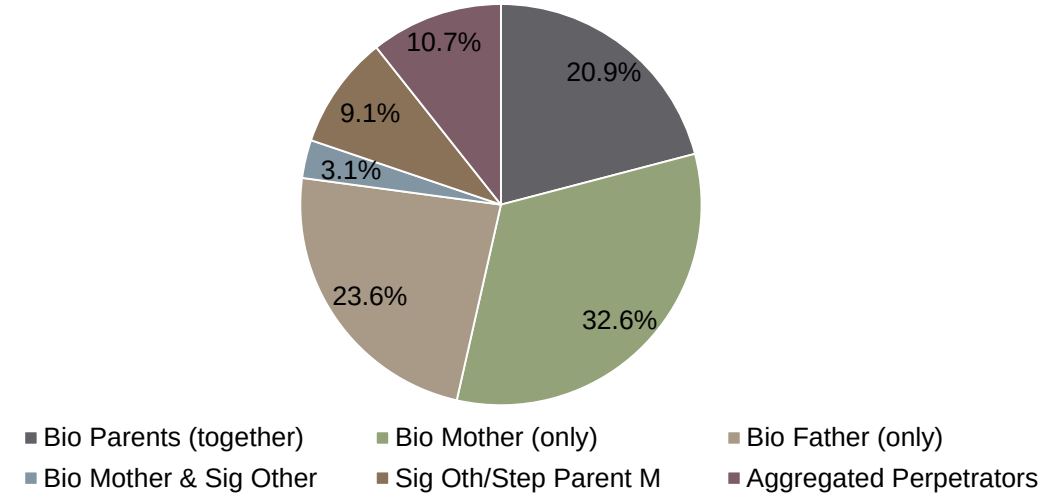
[24] California Department of Social Services. (2017). State of California child fatality annual report - calendar year 2014. Retrieved from http://www.cdss.ca.gov/inforesources/Child-Fatality-and-Near-Fatality/Data-and-Reports

[25] Appendix Tables IV and XI

[26] Excludes 127 cases with an unknown perpetrator and 49 cases where the perpetrator was listed as "other". As child victims are often very young and cared for by multiple individuals, it can be difficult to determine who precisely was the perpetrator of the abuse and neglect, leading to high numbers of unknown perpetrators. In some years, minor perpetrators and some other individuals were classified as "other" rather than "related or unrelated M/F." Due to this inconsistency, the 49 cases with "other" perpetrators were excluded from this analysis.

*Cases listed in "Aggregated Perpetrators" include Female Significant Other/Step Parent, Other Related Female, Other Related Male, Other Unrelated Female, Other Unrelated Male, Adopt Mother, Adopt Father, and Foster Parent Male/Female.

FIGURE 8
2010-2014 Perpetrator of Critical Incidents (n=975)*

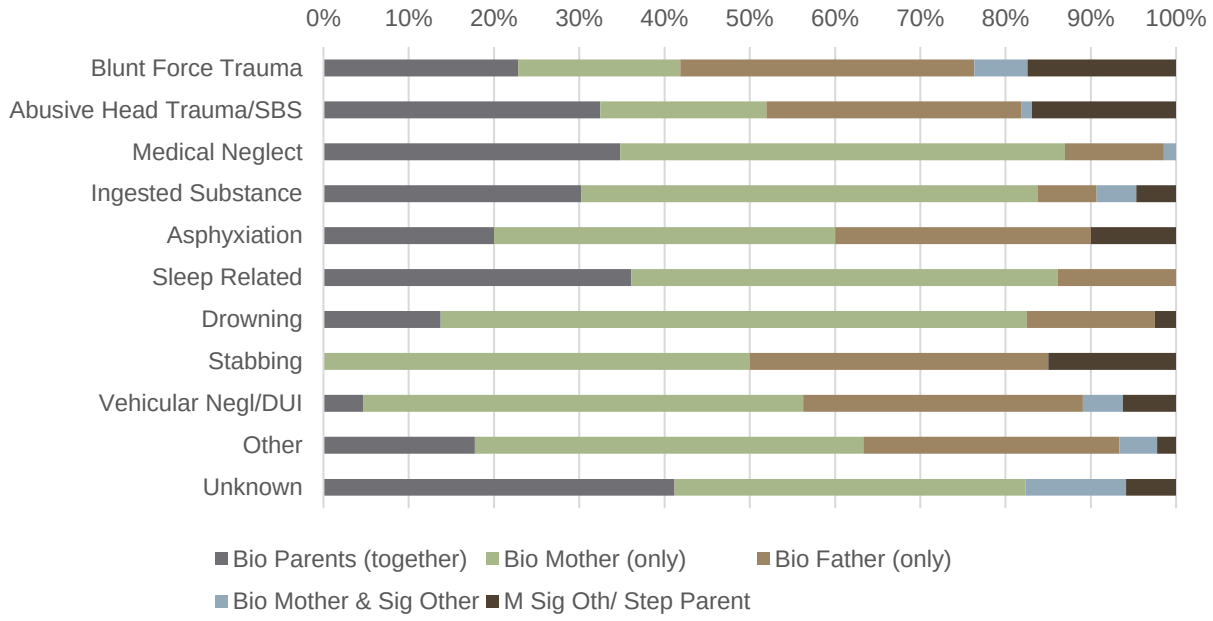


In total, 12.2 percent of fatal or near fatal critical incidents were perpetrated by the mother's male significant other or a stepfather, either alone or with the mother. Female significant others, relatives, foster parents, adoptive parents, and other caregivers each comprised very small percentages of the perpetrators of fatal and near fatal child abuse and neglect.

Biological mothers or parents together were responsible for the majority of neglect-related deaths, such as medical neglect, drowning, or ingested substance. For the two most common causes of death, blunt force trauma and abusive head trauma, mothers were less likely to be the sole perpetrator. Fathers acted alone in a quarter (25 percent) of all blunt force trauma and abusive head trauma critical incidents or acted together with the mother (usually in a situation where the father abuses the child and the mother fails to protect the child) in another 20.2 percent of cases. Finally, the mother's significant other, acting together with the mother, was the perpetrator of physical abuse-related critical incidents in 16.5 percent of cases. In total, nearly two out of every three physical abuse-related critical incidents were perpetrated by a male caregiver (Figure 9).[27]

[27] Excludes 176 cases with unknown or "other" perpetrator (see footnote, page 17).

FIGURE 9
2010-2014 Cause of Critical Incident by Primary Individual Responsible (n=975)



While the majority of fatalities and near fatalities are perpetrated by a biological parent, the mother's significant other was the leading perpetrator of fatal and near fatal abuse after the biological parents, responsible for more than one in ten critical incidents (11.6 percent).[28]

When physical abuse fatalities and near fatalities[29] are combined, the mother's significant other was responsible for 13.7 percent of critical incidents – a number that far surpasses the combined total of every other non-parent perpetrator. Additionally, the mother's male significant other accounted for twice as many fatalities as near fatalities (10.8 percent versus 5.7 percent).[30] These findings are consistent with the NIS-4, which found that children living with a biological parent and the parent's unmarried partner are at 33 times the risk of experiencing abuse, neglect, or endangerment as children living with both married parents.[31]

Aggregated Perpetrators

Perpetrators who were included in the "aggregated perpetrators" category included relative caregivers, unrelated individuals, adoptive parents, and foster parents. Each of these groups was responsible for a very small number of fatalities. The most frequent perpetrator in this category was a related female, usually the grandmother. Related female caregivers were most

[28] Appendix Tables VII and XIV
[29] Physical Abuse incidents included all blunt force trauma, all abusive head trauma, and all stabbings. Drowning, ingested substance, asphyxiation and gunshot were excluded, as data did not indicate if the injury was physical abuse or neglect.
[30] Appendix Tables VII and XIV
[31] Sedlak, A. M. (2010). Fourth National Incidence Study of Child Abuse and Neglect (NIS–4): Report to Congress. Washington, DC: U.S. Department of Health and Human Services, Administration for Children and Families. Retrieved from http://www.acf.hhs.gov/programs/opre/abuse_neglect/natl_incid/index.html

likely to be responsible for neglect-related deaths, particularly drowning or ingested substances. For physical abuse-related critical incidents, the most common perpetrator in this category was an unrelated male, often a friend of the family who was caring for the child.[32]

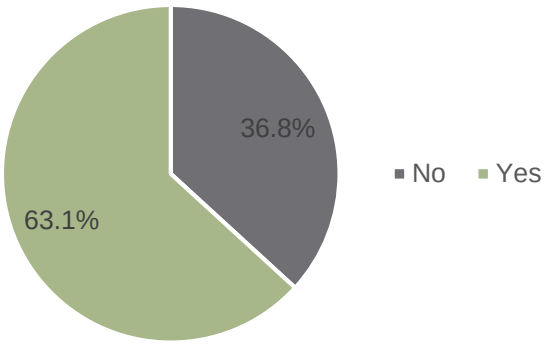
Age of Parent Perpetrators

Eleven percent (105 of 958)[33] of critical incidents perpetrated by biological parents occurred in households with parents age 20 or younger. Eighty-nine percent of biological parents were age 21 or older at the time of the critical incident and more than a third (36.3 percent) of parents responsible were older than 30.[34]

[32] Appendix Tables VII and XIV
[33] Excludes 193 cases where the PIR was unknown, or where the PIR was known but age was not documented.
[34] In situations where both parents are responsible for the fatality, the age of the younger parent was considered in conducting this analysis.

Child Welfare Involvement

FIGURE 10
2011-2014 Critical Incidents with Prior CWS History (n=902)*



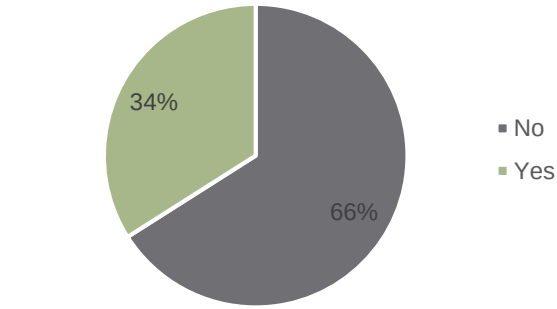
CDSS analyzed data on previous child welfare involvement in families who experienced a critical incident between 2011 and 2014 (data from 2010 was not available to be analyzed). "Prior child welfare involvement" or "child welfare history" were defined as any contact at any time that brought the family to the attention of child welfare, including a report to the hotline, whether or not the report was assigned for an in-person investigation. This also includes prior contact with the parent when they were the victim of abuse or neglect as a child.

From 2011 to 2014, a total of 902 critical incidents reported to CDSS were available to be analyzed for child welfare history.[35] Of these, 570 families (63.1 percent) had prior child welfare history with a CWS agency (Figure 10).

Children who experienced a fatality were more likely to come from a family with prior child welfare contact, compared to near fatality victims. In all, 74.9 percent of child fatalities occurred in families with prior contact in the past, as opposed to 53.1 percent of child near fatalities. This data suggests the increased vulnerability of a child from a family with prior CWS history to have a fatal outcome when compared to a child from a family with no prior CWS history.[36]

As might be expected, the proportion of child victims from families with prior child welfare history increased with a child's age. For example, 60.4 percent of critical incidents involving infants occurred in families with prior child welfare history, a percentage that increased to 76.9 percent when looking at critical incidents among youth ages 15-17. Overall, one-third (34 percent) of all families were known to child welfare within a year of the critical incident, regardless of the age of the victim (Figure 11).[37] [38]

FIGURE 11
2011-2014 Critical Incidents with CWS History within 1 year (n=653)*



[35] Information on child welfare history was not available from 2010 for either fatalities or near fatalities. Information on child welfare history within one year was not available for 2012 and 2013 for near fatalities.
[36] Putnam-Hornstein, E. (2011). Report of maltreatment as a risk factor for injury death: a prospective birth cohort study. Child Maltreatment, 16, 163-174. doi:10.1177/1077559511411179
[37] Excludes near fatality data from 2012 and 2013
[38] Appendix Tables VI and XIII

More than a third (36.8 percent) of families that experienced a critical incident were not known to a child welfare agency (Figure 10), which indicates that fatal or nearly fatal child abuse and neglect can occur without any history of prior reports. Unreported child abuse and neglect exposes children to unhealthy living environments, often for extended periods of time. The Adverse Childhood Experiences Study (ACES) demonstrated that any abuse, even abuse that occurs only once or twice, could have a detrimental effect on an individual's lifelong health and well-being.[39] One strategy to reduce unreported abuse and neglect is through community messaging and training to ensure the general public along with mandated reporters are made aware of the signs of child abuse and neglect and the process for reporting.

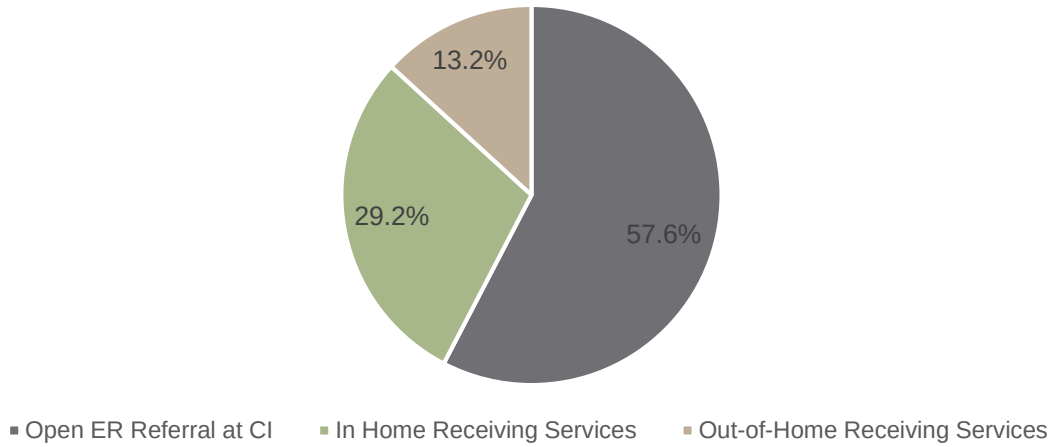
Most Recent Referral

Detailed data on child welfare involvement within one year was available for 653 of the 902 critical incidents in which the family had prior CWS involvement at any point in the past. Of these 653 incidents, 222 (34 percent) had CWS involvement within one year prior to the critical incident. Half of the families with history within a year had multiple referrals to child welfare in that timeframe. These findings have remained consistent over prior years for both child fatalities and near fatalities.

Child Welfare Involvement at the Time of Critical Incident

Of the 902 critical incidents reported to CDSS that occurred between 2011 and 2014, a combined 144 (16 percent) had CWS involvement at the time of the critical incident. Of these 144, 83 (57.6 percent) had an open emergency response investigation and 61 (42.4 percent) had an open CWS case (in home or out of home) at the time of the critical incident (Figure 12).

FIGURE 12
2011-2014 CWS Involvement at Time of Critical Incident (n=144)



[39] Felitti, V. A. (1998). Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults. American Journal of Preventative Medicine, 245-258. Retrieved from http://www.iowaaces360.org/uploads/1/0/9/2/10925571/relationship_of_childhood_abuse_and..._1998.pdf

Children in Open Emergency Response Investigations

Child fatalities in 2014 with open emergency response investigations at the time of the critical incident were analyzed in the 2014 Child Fatality Report.[40] The major findings of that analysis were that, while most investigations met the majority of regulatory and assessment requirements, nearly every investigation missed at least one required element or assessment. In particular, half of investigations lacked important documentation of interviews with collateral contacts (such as contact with the child's teachers, doctors, neighbors, or others who are outside the immediate family but may have critical information to assist in the assessment process). Additionally, the SDM Safety Assessment Tool was completed inaccurately in a quarter of cases when compared to information contained within investigative documents; it was not completed at all in an additional 20 percent of cases reviewed. The findings were similar to a review of Los Angeles County conducted by the Los Angeles County Office of Child Protection. In that review, the SDM Safety Tool was identified as being used in only 17 percent of cases, and in the cases where the tool was used, it was used either incorrectly or inaccurately 64 percent of the time.[41] SDM assessment tools are designed to guide consistent and comprehensive decision-making, and their proper and complete use may assist in achieving better outcomes for families, including a decrease in child fatalities and near fatalities.

Children in Open Cases

Between 2011 and 2014, 61 children suffered a critical incident while their family was involved in an open child welfare case. Forty-two (68.8 percent) of these children were residing with their family in a family maintenance case and 19 children (31.1 percent) suffered a critical incident while placed in foster care.

Out of Home Placement

Of the 19 critical incidents that occurred in foster care, five (26.3 percent) were perpetrated by the biological parents during a visitation or trial visit home, and one child (5.3 percent) died in foster care as the result of injuries sustained years previously at the hands of the biological parents. Ten critical incidents (52.6 percent) were perpetrated by the foster parent, two (10.5 percent) by an unrelated adult male (one by a babysitter and one by the foster mother's boyfriend), and in one case (5.3 percent) the perpetrator was unknown.

Of the ten children who experienced fatal or near fatal abuse at the hands of a foster parent, four (40 percent) were placed with relatives or family friends, and six (60 percent) were placed with unrelated foster families. As with all child fatalities, blunt force trauma or abusive head trauma were the most common causes of injury or death.

[40] California Department of Social Services. (2017). State of California child fatality annual report - calendar year 2014. Retrieved from http://www.cdss.ca.gov/inforesources/Child-Fatality-and-Near-Fatality/Data-and-Reports

[41] Nash, M. (2017, May 4). Examination of using Structured Decision Making and predictive analytics in assessing safety and risk in child welfare. Report to the Board of Supervisors. Los Angeles.

In Home with Family Maintenance Services

CDSS conducted a separate analysis of 39 cases whose families were in an open in-home child welfare case and suffered a critical incident while in the care of the biological parents. For further details on how the following 39 cases were analyzed see the methodology section.

When looking at each of the aforementioned assessed areas individually, findings indicated that county caseworkers almost always met their requirement to regularly visit the child and family in an open case (92.3 percent of children and 74.4 percent of families were visited regularly) and that most (84.6 percent) of the investigations that led to the opening of a case met all regulatory requirements. Some caseworkers also provided a much higher level of service than the minimum requirements, such as visiting families as often as once a week.

FIGURE 13
2011-2014 Findings from Open Cases with a Critical Incident (n=39)

Assessed Area	Number[42]	Percent
Investigation met all requirements	33	84.6%
At least one visit every thirty days with child	36	92.3%
At least one visit every thirty days with parent	29	74.4%
Services assigned matched family's needs	32	82.1%
Services were effective	18	46.2%

However, when looking at the open family maintenance cases and referrals *combined* (as opposed to investigations or cases separately), reviewers assessed that in 24 of the 39 critical incidents in an open family maintenance case (61.5 percent), at least one element of a complete investigation or case plan was missing – either the investigation that preceded the critical incident was lacking a critical component, the child or family was not visited regularly or the services provided did not meet the family's needs. One example included a situation where the social worker did not interview a father or assess his home before placing the child in his care, despite documented domestic violence concerns. In another case, parents who had come to the attention of child welfare due to domestic violence did not document referrals pertinent to the family's prioritized needs.

Of the elements reviewed, services offered to the families stood out as the area most in need of improvement. In seven cases (17.9 percent), the reviewer assessed that the services provided did not appear to meet the family's needs, meaning that a need was documented but not included in the court-ordered or offered services.

In 21 situations (53.8 percent), the offered services may have been appropriate for the family's needs, but the parent did not participate in or successfully complete them. Examples included parents who were referred to mental health services but did not attend for months or parents who repeatedly failed substance abuse tests or failed to attend required classes.

[42] This number includes some cases that apply to multiple assessed areas.

Need for Improved Services

Social workers must regularly evaluate whether parents are engaging in services they are referred to, and to work with families if the offered service is not meeting that family's needs. Additionally, best practice indicates that services should be tailored to each family's needs and that families should promptly receive the services that would benefit them.

While many counties may face challenges with the availability of an array of services, CWS agencies should consider alternative services when families are unsuccessful in the most common services. CWS agencies are encouraged to develop relationships with a wide variety of service providers and community partners in order to protect children by ensuring that their parents can access the level of help they need. Counties are also encouraged to prioritize evidence-based service providers and programs when considering where to refer families. If a parent has been unsuccessful in modifying their behavior with the most intensive service available, then the CWS agency in conjunction with the court must consider if the child can be maintained safely at home.

Conclusion

A five-year analysis of child maltreatment fatalities and near fatalities confirmed many known characteristics while revealing some previously unreported nuances. Children under age one experienced critical incidents at a rate that is disproportionate to their share of the statewide child population. Deaths related to physical abuse are the most common and are most frequently perpetrated by a male caregiver, highlighting the need to improve outreach and prevention services for male caregivers and the need to improve investigation and assessment techniques as they relate to physical abuse. Finally, the fact that over half of child fatalities occur in families known to child welfare identifies a potential opportunity to intervene through stronger assessment by child welfare workers and improved access to services.

These findings point to the need for strong statewide support for programs that support child welfare agencies and vulnerable families. Several possible programs and strategies are discussed in the recommendations section at the beginning of this report.

Methodology

Data Collection

Counties are required to report all child fatalities and near fatalities to CDSS, in accordance with WIC 10850.4(j), All County Letter (ACL) 06-24 and ACL 16-109. In order to implement federal and state disclosure and reporting requirements regarding child fatalities and near fatalities, CDSS developed and adopted the County Statement of Findings and Information (SOC 826) form, which is submitted when a county has determined that a child fatality or near fatality was caused by abuse or neglect. These forms are collected and reviewed by staff within CDSS.

In addition to fatalities and near fatalities reported via the SOC 826, CDSS seeks to identify child abuse or neglect related fatalities by monitoring the media for incidents and conducting regular reconciliations with CDSS Community Care Licensing Division and data from the Child Welfare Services Case Management System (CWS/CMS). If a fatality or near fatality that has not been reported is identified, CDSS contacts the responsible county to request that county staff submit the appropriate documentation to allow the fatality or near fatality to be reviewed and included in a future Annual Report.

This report contains a comprehensive analysis of the 543 child fatalities and 608 near fatalities (a total of 1,151 critical incidents) that have been received and analyzed by CDSS for calendar years 2010-2014 (this total includes 84 near fatalities from 2013 that received an abbreviated review). This total excludes 117[43] incidents that did not meet the criteria for review.

Incidents did not meet review criteria under one of the following circumstances:

- The case was reported too late in that year's review period to be reviewed.
- The critical incident matched the definition of a third-party incident, defined as an incident where the perpetrator is a person other than the parent, guardian or person acting as caregiver and there was no contributory abuse or neglect by a parent, guardian or caregiver.

Analysis

CDSS staff thoroughly analyzed each fatality and near fatality using information that was gathered from the CWS/CMS and the SDM tool, a suite of assessment instruments that help guide social worker decision making. For the years reviewed, a "near fatality" was defined as "a severe childhood injury or condition caused by abuse or neglect which results in the child receiving critical care for at least 24 hours following the child's admission to a critical care unit(s)."[44]

[43] Reports received as of August 2, 2017

[44] AB 1625 amended the definition of "near fatality," bringing it into conformity with the definition described in the federal Child Abuse Prevention and Treatment Act (CAPTA). For all incidents occurring on or after

For each case review, the following data elements were extracted and analyzed:

- Demographic information on the child victim, including age, sex, and race/ethnicity.
- Demographic information on the perpetrator(s), including age, sex, race/ethnicity, and relationship to the victim.
- The cause of the fatality or near fatality.
- CWS history, including any prior investigations, risk and safety assessments, and case plans dating from within five years prior to the fatality.

In addition to the case review, CDSS consulted with individual counties on data elements that were initially identified as unknown or undetermined in an effort to gather more specific and current information about the causes and individuals responsible for such incidents.

Researchers at the California Child Welfare Indicators Project (CCWIP) at the University of California, Berkeley provided assistance with the production of tables based upon the data. CDSS analysts produced the final analysis presented in the report.

CDSS makes every effort to identify as many child fatalities and near fatalities as possible in advance of issuing the annual report. However, some incidents are reported only after analysis has been completed for a given report. The most recent data on child fatality and near fatality incidents reported to CDSS can be viewed on the CDSS website at http://www.cdss.ca.gov/inforesources/Child-Fatality-and-Near-Fatality/Data-and-Reports

In Home with Family Maintenance Services

Forty-six children whose families were in an open in-home child welfare case suffered a critical incident while in the care of the biological parents. In seven cases, the parents were receiving services for a sibling of the victim child, but the victim child was not a dependent of the court. These cases were excluded from the analysis. For the remaining 39 cases CDSS reviewed referral documentation that led to an open case and the critical incident referral to identify causes and trends of children who suffered a fatal or nearly fatal incident while receiving family maintenance services.

Specifically, CDSS case reviewers assessed the following areas:

- If the investigation that preceded the case opening met all regulatory requirements
- If the child was visited at least once a month while in a case plan
- If the parent(s) were visited at least once a month while in a case plan
- If the services provided matched the family's documented needs
- If the services were effective (i.e., if the parent participated in and successfully completed the services).

January 1, 2017, a "near fatality" is defined as "an act that, as certified by a physician, places the child in serious or critical condition."

Note on Third Party Homicide Incidents

Third party homicides are distinguished from other child abuse and neglect homicides by the perpetrator relationship to the child. Third party homicides are defined as "a child homicide by a perpetrator other than the parent, guardian or person acting as a caregiver, and in which no contributing abuse or neglect by a parent, guardian or caregiver was found."

Some counties have a policy of reporting all child homicides to the CDSS, regardless of the perpetrator's relationship to the child. CDSS accepts these reports and assesses each third-party homicide report to determine if the report meets the criteria for review per WIC 10850.4 (j). A report is not reviewed if it is determined that the incident was not caused by a parent, guardian or person acting as a caregiver and there was no contributory neglect by a parent, guardian or caregiver. Therefore, a full case review of third party homicides is not conducted nor reported out on.

Limitations

2013 Abbreviated Review

Until 2017, an annual review of child near fatalities was not required by California statute. In an effort to promote public transparency and better practice, CDSS has produced combined reports on child fatalities and near fatalities since 2008. However, due to a combination of circumstances, CDSS faced a backlog of un-reviewed cases from 2012 and 2013. In an effort to begin producing annual reports in a prompt fashion, CDSS chose to review a statistically significant number of near fatalities in 2013 in order to provide an accurate idea of trends. CDSS reviewed 35 randomly selected near fatalities from 2013, leaving unknown detailed data for 84 near fatalities. These 84 fatalities are included in the total count of 1,151 critical incidents, and known demographic data from those incidents is included where possible in the analysis.

Incidents That Are Not Investigated by Child Welfare

Some child fatality incidents may not be investigated by child welfare, usually in the event of a fatality where there are no other children in the home. These fatalities usually are investigated by law enforcement. As a result, the case files for these incidents may provide less detailed investigatory information within CWS/CMS than might otherwise be available in a fatality investigated by a CWS agency. Additionally, even for cases where child welfare does investigate, CDSS' review is limited to information uploaded to the CWS/CMS and SDM tool. Any information held by the coroner or law enforcement is not readily available for the review. Due to the limitation of available information from other agencies, some case reviews may not accurately reflect pertinent information needed for data collection.

Underreporting of Fatalities and Near Fatalities

Underreporting of child abuse and neglect fatalities and near fatalities is a challenge recognized nationwide[45] that occurs for a number of reasons. In the case of child near fatalities, child welfare may be made aware of a case, but face challenges in determining the threshold for defining and reporting a near fatality. In the case of child fatalities, a death that occurs in a household with no siblings may not prompt a call to child welfare, and lengthy court trials may delay reporting. Additionally, data-sharing between coroners, law enforcement, and child welfare agencies may also pose a challenge. CDSS makes every effort to collect as much available information as possible about child fatalities and near fatalities and is actively working to improve and increase its data collection efforts with its law enforcement and coroner/medical examiner counterparts.

Statistical Challenges

The number of child abuse and neglect fatality incidents reported to CDSS is small when compared to the overall child welfare population and the statewide child population. In addition to percentages and raw numbers, this report presents rates to control for fluctuations in the statewide child population and allow for comparisons over time and between groups. Individuals who read this report are cautioned against generalizing the data to child welfare cases overall.

Additional Information

Terminology

CDSS refers to a child fatality or near fatality as a "critical incident." This term will be used throughout this report to refer to child fatalities and near fatalities collectively.

Population Data

All state-level population data cited in the report and used to calculate rates was retrieved from the California Department of Finance Estimates of Race/Hispanics Population with Age & Sex Detail tables, available at http://www.dof.ca.gov/Forecasting/Demographics/Estimates. Population data is restricted to children ages 0-17.

Rounding

All reported percentages have been rounded to one decimal point, with the exception of numbers that had a decimal point of 0, which were presented as the whole number. As the result of rounding, some columns may total slightly more or less than 100.

Appendix Tables

All data and appendices reflect reviewed child fatality and near fatality cases. The data presented here reflects all reported child fatalities and near fatalities as of March 31, 2016.

[45] Commission to Eliminate Child Abuse and Neglect Fatalities. (2016). Within our reach: A national strategy to eliminate child abuse and neglect fatalities. Washington, DC: Government Printing Office. Retrieved from http://www.acf.hhs.gov/programs/cb/resource/cecanf-final-report

Glossary

For the purposes of this report, the following definitions are used:

Abuse
The non-accidental commission of injuries against a person. In the case of a child, the term refers specifically to the non-accidental commission of injuries against the child by or allowed by a parent(s)/guardian(s) or other person. The term also includes emotional, physical, severe physical, and sexual abuse.

Abusive Head Trauma
An injury to the skull or intracranial contents of an infant or young child (under five years of age) due to inflicted blunt impact or violent shaking. Includes what was previously referred to as Shaken Baby Syndrome.

Allegation
A report concerning a specific form of abuse. Examples of allegations include physical abuse, sexual abuse, emotional abuse, general neglect, severe neglect, and exploitation. A single referral may contain more than one allegation (for example, physical abuse and general neglect).

Asphyxia
To cause to die or lose consciousness by impairing normal breathing, as by gas or other noxious agents; choke; suffocate; smother.

Blunt Force Trauma
Injuries resulting from an impact with a dull, firm surface or object. Individual injuries may be patterned (e.g., characteristics of the wound suggest a particular type of blunt object) or nonspecific. Includes blunt force trauma to the body or head.

Burn
An incident from injuries to tissues caused by heat, friction, electricity, radiation, or chemicals.

Case
Services provided to families in crisis to prevent or remedy abuse or neglect. Case plans may be voluntary or court ordered.

- Family Maintenance: activities designed to provide in-home protective services to prevent or remedy neglect, abuse, or exploitation, for the purposes of preventing separation of children from their families.

- Family Reunification: activities designed to provide time-limited foster care services to prevent or remedy neglect, abuse, or exploitation, when the child cannot safely remain at home, and needs temporary foster care, while services are provided to reunite the family.

- Permanent Placement: activities designed to provide an alternate permanent family structure for children who because of abuse, neglect, or exploitation cannot safely remain at home and who are unlikely to ever return home.

Critical Incident
A child fatality or near fatality that has been determined to be the result of abuse or neglect.

Determination
A conclusion by an agency as to whether the child fatality or near fatality was the result of abuse or neglect. Abuse or neglect is determined to have led to a child's death if any one of the following conditions is met:

- A county child protective agency determines that the abuse or neglect was substantiated.
- A law enforcement investigation concludes that abuse or neglect occurred.
- A coroner/medical examiner concludes that the child who died had suffered abuse or neglect.

Drowning/Near-Drowning
A process where a liquid-air interface is present at the entrance to the victim's airway, which prevents the individual from breathing oxygen, resulting in respiratory impairment and possible fatality.

Evaluated Out
A referral alleging child abuse or neglect that does not meet the criteria for investigation. These referrals may be closed with no further action, or a referral to a community agency may be provided, as appropriate.

Gunshot
An incident in which the victim was shot by a firearm intentionally or unintentionally.

Infant
A child between birth and one year of age.

Ingested Substance
An incident caused by an object or substance that entered a child's body through the mouth.

Near Fatality
For child near fatalities that occurred between 2010 and 2014, this term was defined as a severe childhood injury or condition caused by abuse or neglect which results in the child receiving critical care for at least 24 hours following the child's admission to a critical care unit(s).

In 2016, AB 1625 amended the definition of “near fatality,” bringing it into conformity with the definition described in the federal Child Abuse Prevention and Treatment Act (CAPTA). For all incidents occurring on or after January 1, 2017, a “near fatality” is defined as “an act that, as certified by a physician, places the child in serious or critical condition.”

Neglect

The failure to provide a person with necessary care and protection. In the case of a child, the term refers to the failure of a parent(s)/guardian(s) or caretaker(s) to provide the care and protection necessary for the child’s healthy growth and development. Neglect occurs when children are physically or psychologically endangered.

> General Neglect: The negligent failure of a person having the care or custody of a child to provide adequate food, clothing, shelter, medical care, or supervision where no physical injury to the child has occurred.
>
> Severe Neglect: The negligent failure of a person having the care or custody of a child to protect the child from severe malnutrition or medically diagnosed nonorganic failure to thrive. "Severe neglect" also means those situations of neglect where any person having the care or custody of a child willfully causes or permits the person or health of the child to be placed in a situation such that his or her person or health is endangered, as proscribed by Penal Code Section 11165.3, including the intentional failure to provide adequate food, clothing, shelter, or medical care.
>
> Medical Neglect: The denial or deprivation, by those responsible for the care, custody, and control of the child, of medical or surgical treatment or intervention which is necessary to remedy or ameliorate a medical condition which is life threatening or causes injury. Medical neglect includes not only serious but also mild and moderate medical neglect as well.

Referral

A referral that alleges child abuse, neglect, or exploitation. A referral may be made by a call to the Child Abuse Hotline, a Suspected Child Abuse Report submitted by a mandated reporter, or a cross-report from a law enforcement, licensing, or other agency.

Shaken Baby Syndrome

See: Abusive Head Trauma

Sleep-Related Death

Deaths where a child less than one-year-old dies while sleeping.

Stabbing

An incident in which the victim was pierced or wounded by a pointed instrument.

Structured Decision Making (SDM)

A suite of assessment tools designed to help social workers make accurate, consistent and non-biased decisions at critical stages of a child welfare investigation and case.

Substance Abuse
Caregiver has abused legal or illegal substances or alcoholic beverages to the extent that control of his/her actions or caregiving abilities is significantly impaired, or information is available that past abuse of legal or illegal substances has impaired the parent's caregiving capabilities in the past.

Substantiated Report
A report that is determined by the social worker who conducted the investigation to constitute child abuse or neglect, based upon evidence that makes it more likely than not that child abuse or neglect, as defined, occurred. A substantiated report shall not include a report where the investigator who conducted the investigation found the report to be false, inherently improbable, to involve an accidental injury, or to not constitute child abuse or neglect.

Suicide
Death caused by self-directed injurious behavior with any intent to die as a result of the behavior.

Third Party Homicide
Situations wherein a child was a victim of homicide by a perpetrator other than a parent/guardian or a person acting as a caregiver and there was no contributory abuse or neglect by a parent, guardian or caregiver.

Unfounded report
A report of child abuse, which is determined by a child protective agency investigator to be false, to be inherently improbable, to involve an accidental injury, or not to constitute child abuse.

Vehicular DUI/Negligence

> DUI: An incident as a result of the caretaker operating a vehicle while under the influence of alcohol or drugs. This includes persons who are operating a vehicle while having .08 alcohol (of their weight) in their system.
>
> Negligence: An incident as a result of the perpetrator operating a vehicle in an unreasonable or unlawful manner (i.e. speeding, not restraining child in carseat etc.)

Appendices – Child Fatalities

I. 2010-2014 Child Population, Child Fatalities, and Rate per 100,000

	Child Population						Child Fatalities						Fatality Rate				
	2010	**2011**	**2012**	**2013**	**2014**		**2010**	**2011**	**2012**	**2013**	**2014**		**2010**	**2011**	**2012**	**2013**	**2014**
Total	**9,273,754**	**9,203,420**	**9,149,419**	**9,104,860**	**9,097,971**		**128**	**119**	**111**	**97**	**88**		**1.38**	**1.29**	**1.21**	**1.07**	**0.97**
Age Group																	
<1 Yr. Old	493,399	506,768	495,240	497,410	502,818		53	58	56	44	35		10.74	11.45	11.31	8.85	6.96
1-4 Yrs. Old	2,033,169	2,013,325	2,005,213	1,989,392	1,998,347		53	35	36	32	35		2.61	1.74	1.80	1.61	1.75
5-9 Yrs. Old	2,504,035	2,501,508	2,524,358	2,537,336	2,536,409		11	14	10	12	8		0.44	0.56	0.40	0.47	0.32
10-14 Yrs. Old	2,583,627	2,553,685	2,529,056	2,515,768	2,514,558		6	7	6	8	7		0.23	0.27	0.24	0.32	0.28
15-17 Yrs. Old	1,659,524	1,628,134	1,595,552	1,564,954	1,545,839		5	5	3	1	3		0.30	0.31	0.19	0.06	0.19
Sex																	
Female	4,528,816	4,497,506	4,473,282	4,453,134	4,451,179		62	48	51	39	35		1.37	1.07	1.14	0.88	0.79
Male	4,744,938	4,705,914	4,676,137	4,651,726	4,646,792		66	71	60	58	53		1.39	1.51	1.28	1.25	1.14
Race/ Ethnicity*																	
Black	527,695	516,416	503,885	493,035	487,981		29	20	21	24	14		5.50	3.87	4.17	4.87	2.87
Hispanic	4,747,973	4,722,627	4,697,887	4,669,624	4,675,027		56	50	46	37	29		1.18	1.06	0.98	0.79	0.62
White	2,560,676	2,526,028	2,505,391	2,486,123	2,465,851		29	27	17	24	22		1.13	1.07	0.68	0.97	0.89
Asian/P.I.	1,006,311	1,001,196	999,957	1,008,249	1,017,657		4	6	4	2	-		0.40	0.60	0.40	0.20	-
Nat American	37,975	37,148	36,289	35,620	35,119		1	-	-	-	1		2.63	-	-	-	2.85
Multi-Race	393,124	400,005	406,010	412,209	416,336		-	10	8	7	14		-	2.50	1.97	1.70	3.36

*Children with Other or Not Documented Race/Ethnicity are excluded

II. 2010-2014 Child Fatalities - Characteristics by Year

Characteristic	TOTAL	2010	2011	2012	2013	2014
	n	n	n	n	n	n
Total	**543**	**128**	**119**	**111**	**97**	**88**
Sex						
Female	**235**	62	48	51	39	35
Male	**308**	66	71	60	58	53
Race / Ethnicity*						
Black	**108**	29	20	21	24	14
Hispanic	**218**	56	50	46	37	29
White	**119**	29	27	17	24	22
Asian/Pacific Islander	**16**	4	6	4	2	-
Native American	**2**	1	-	-	-	1
Multi-Race	**39**	-	10	8	7	14
Other	**3**	-	1	2	-	-
Not Documented	**38**	9	5	13	3	8
Age Group						
<1 Yr. Old	**246**	53	58	56	44	35
1-4 Yrs. Old	**191**	53	35	36	32	35
5-9 Yrs. Old	**55**	11	14	10	12	8
10-14 Yrs. Old	**34**	6	7	6	8	7
15-17 Yrs. Old	**17**	5	5	3	1	3
Subtotal 2011-2014*	**415**		**119**	**111**	**97**	**88**
Age Group (1-4 yr. breakout) *						
<1 Yr. Old	**193**		58	56	44	35
1 Yrs. Old	**57**		18	12	13	14
2 Yrs. Old	**44**		8	12	11	13
3 Yrs. Old	**18**		5	5	4	4
4 Yrs. Old	**19**		4	7	4	4
5-9 Yrs. Old	**44**		14	10	12	8
10-14 Yrs. Old	**28**		7	6	8	7
15-17 Yrs. Old	**12**		5	3	1	3
Infant Subtotal 2011-2014	***193***		***58***	***56***	***44***	***35***
Infant Age Group**						
0 to 3 months	**108**		31	32	22	23
4 to 6 months	**31**		10	10	8	3
7 to 11 months	**54**		17	14	14	9
Fatality Location						
Home	**532**	124	117	109	97	85
Foster Care	**11**	4	2	2	-	3
Finding Incident Due to						
Crime	**247**	45	58	52	46	46
Suicide	**2**	-	2	-	-	-

Characteristic	TOTAL	2010	2011	2012	2013	2014
Non-Accidental	**158**	49	29	29	26	25
Undetermined	**6**	2	3	1	-	-
Other	**130**	32	27	29	25	17
Cause of Fatality						
Blunt Force Trauma	**173**	34	37	35	44	23
Abusive Head Trauma / SBS	**36**	8	14	-	2	12
Medical Neglect	**25**	6	4	6	4	5
Ingested Substance	**18**	1	2	6	4	5
Malnourishment	**6**	-	2	2	1	1
Asphyxiation	**42**	7	12	11	6	6
Sleep Related	**40**	10	10	11	5	4
Drowning	**63**	17	10	13	13	10
Maternal Drug Use	**6**	2	-	3	-	1
Gunshot	**30**	8	7	9	5	1
Stabbing	**20**	6	1	3	1	9
Suicide	**4**	2	2	-	-	-
Vehicular Neglect/DUI	**35**	6	5	7	9	8
Burns/Fire	**14**	6	5	1	-	2
Victim Abandoned /Hypothermia	**8**	2	4	-	1	1
Mauled	**1**	1	-	-	-	-
Other	**2**	2	-	-	-	-
Undetermined	**15**	5	4	4	2	-
Missing	**5**	5	-	-	-	-
Allegation of Critical Incident						
None	**7**	7	-	-	-	-
Abuse	**175**	42	42	28	35	28
Neglect	**264**	61	53	65	48	37
Abuse & Neglect	**94**	18	24	17	12	23
Other	**3**	-	-	1	2	-
Primary Individual(s) Responsible Relation to Child Victim**						
Bio Parents (together)	**91**	15	25	18	12	21
Bio Mother (only)	**169**	34	37	41	29	28
Bio Father (only)	**123**	32	29	24	24	14
Bio Mother & Sig Other	**13**	4	3	2	3	1
F Sig Other/Step Parent	**4**	2	-	2	-	-
M Sig Other/Step Parent	**54**	8	16	7	15	8
Other Related F	**11**	3	1	1	1	5
Other Related M	**8**	1	-	2	1	4
Other UnRelated F	**8**	-	-	4	2	2
Other Unrelated M	**11**	1	3	1	4	2
Adopt Mother	**3**	-	-	-	2	1
Adopt Father	**1**	1	-	-	-	-
Foster Parent M/F	**8**	4	1	1	-	2
Other	**39**	23	4	8	4	-
Primary Individual Responsible #2 Relation to Child Victim***						
None	**519**	118	113	109	94	85
Related (F)	**1**	1	-	-	-	-

Characteristic	TOTAL	2010	2011	2012	2013	2014
Related (M)	**2**	-	1	-	-	1
Unrelated (F)	**3**	1	1	-	-	1
Unrelated (M)	**14**	5	3	2	3	1
Other	**4**	3	1	-	-	-
Primary Individual(s) Responsible Age****						
<16 years old	**1**	-	-	-	1	-
16-20 years old	**57**	16	10	15	8	8
21-23 years old	**88**	15	19	20	14	20
24-26 years old	**92**	21	25	19	21	6
27-30 years old	**90**	21	18	13	19	19
31-35 years old	**70**	8	17	18	17	10
36-40 years old	**39**	9	12	8	4	6
41-45 years old	**26**	4	7	4	5	6
46-60 years old	**27**	6	7	5	3	6
60+ years old	**3**	1	-	-	1	1
Missing	**50**	27	4	9	4	6
Primary Individual Responsible #1 Race/Ethnicity*****	**415**	**0**	**119**	**111**	**97**	**88**
Black	**80**		18	24	22	16
Hispanic	**161**		48	42	40	31
White	**98**		35	21	20	22
Asian/Pacific Islander	**9**		3	4	2	-
Native American	**2**		-	-	1	1
Multi-Race	**15**		-	4	6	5
Other	**8**		5	3	-	-
Missing	**42**		10	13	6	13

** Multi-Race category and Detailed Age information was not available in 2010*

*** Bio parents together, Bio Mother w/Male Sig Other, & Bio Father w/Female Sig Other categories are a combination of the Primary Individual Responsible #1 and Primary Individual Responsible #2 Relationship to Child*

****Bio parents together, Bio Mother w/Male Sig Other, & Bio Father w/Female Sig Other are coded as None since they are represented elsewhere*

***** When two individuals were listed as responsible (Primary Individual(s) Responsible Relation to Child Victim) the age of youngest was utilized.*

******Race/Ethnicity data not available for 2010*

III. 2010-2014 Child Fatalities - Demographic Characteristics of Infant Victims

	TOTAL					2010					2011			
	5 Year Total	0-3 month	4-6 month	7-11 month		2010 Total	0-3 month	4-6 month	7-11 month		2011 Total	0-3 month	4-6 month	7-11 month
Total	**193**	**108**	**31**	**54**							**58**	**31**	**10**	**17**
Sex														
Female	**80**	50	8	22							**22**	13	3	6
Male	**113**	58	23	32							**36**	18	7	11
Race / Ethnicity														
Black	**37**	19	7	11							**12**	5	3	4
Hispanic	**71**	36	10	25							**22**	11	2	9
White	**43**	25	9	9							**11**	5	4	2
Asian/Pacific Islander	**6**	5	0	1							**3**	3	0	0
Native American	**1**	1	0	0							**0**	0	0	0
Multi-Race	**21**	12	3	6							**5**	3	1	1
Other	**2**	1	0	1							**1**	0	0	1
Not Documented	**12**	9	2	1							**4**	4	0	0

	2012					2013					2014			
	2012 Total	0-3 month	4-6 month	7-11 month		2013 Total	0-3 month	4-6 month	7-11 month		2014 Total	0-3 month	4-6 month	7-11 month
Total	**56**	**32**	**10**	**14**		**44**	**22**	**8**	**14**		**35**	**23**	**3**	**9**
Sex														
Female	**25**	18	2	5		**18**	8	2	8		**15**	11	1	3
Male	**31**	14	8	9		**26**	14	6	6		**20**	12	2	6
Race / Ethnicity														
Black	**8**	3	2	3		**10**	5	2	3		**7**	6	0	1
Hispanic	**19**	10	3	6		**20**	9	4	7		**10**	6	1	3
White	**13**	9	3	1		**9**	5	1	3		**10**	6	1	3
Asian/Pacific Islander	**2**	1	0	1		**1**	1	0	0		**0**	0	0	0
Native American	**0**	0	0	0		**0**	0	0	0		**1**	1	0	0
Multi-Race	**6**	4	0	2		**4**	2	1	1		**6**	3	1	2
Other	**1**	1	0	0		**0**	0	0	0		**0**	0	0	0
Not Documented	**7**	4	2	1		**0**	0	0	0		**1**	1	0	0

*****Detailed age data not available for 2010

III. 2010-2014 Child Fatalities – Cause by Victim Demographics

TOTAL	Total	Blunt Force Trauma	Abusive Head Trauma / SBS	Drowning	Vehicular Negligence	Stabbing	Asphyxiation	Ingested Substance	Medical Neglect	Sleep Related	Other	Missing
Total	543	173	36	63	35	20	42	18	25	40	71	20
Sex												
Female	**235**	76	15	29	15	10	19	5	10	13	33	10
Male	**308**	97	21	34	20	10	23	13	15	27	38	10
Race / Ethnicity*												
Black	**108**	39	4	8	5	2	10	3	8	9	14	6
Hispanic	**218**	72	18	31	20	9	8	4	8	15	27	6
White	**119**	35	8	12	6	4	12	8	3	8	19	4
Asian/Pacific Islander	**16**	*	*	*	*	*	*	*	*	*	*	*
Native American	**2**	*	*	*	*	*	*	*	*	*	*	*
Multi-Race	**39**	12	2	4	4	3	4	-	4	2	2	2
Other/Not Documented	**41**	11	1	8	-	2	1	2	1	5	8	2
Age Group												
<1 Yr. Old	**246**	75	26	16	4	6	28	10	9	40	20	12
1-4 Yrs. Old	**191**	85	8	34	10	7	10	3	7	-	21	6
5-9 Yrs. Old	**55**	9	2	11	12	3	1	2	3	-	10	2
10-14 Yrs. Old	**34**	3	-	1	7	4	3	2	6	-	8	-
15-17 Yrs. Old	**17**	1	-	1	2	-	-	1	-	-	12	-
Subtotal 2011-2014**	**415**	137	24	46	29	14	32	16	19	28	48	22
Age Group (1-4 yr. breakout)**												
<1 Yr. Old	**193**	62	19	14	2	5	22	10	7	30	15	7
1 Yrs. Old	**57**	30	1	10	-	2	6	-	1	-	4	3
2 Yrs. Old	**44**	25	5	7	-	1	1	1	1	-	3	-
3 Yrs. Old	**18**	9	-	2	3	-	2	-	1	-	1	-
4 Yrs. Old	**19**	4	1	3	5	1	-	1	1	-	3	-
5-9 Yrs. Old	**44**	6	2	9	12	2	1	2	2	-	8	-

TOTAL	Total	Blunt Force Trauma	Abusive Head Trauma / SBS	Drowning	Vehicular Negligence	Stabbing	Asphyxiation	Ingested Substance	Medical Neglect	Sleep Related	Other	Missing
10-14 Yrs. Old	**28**	2	-	-	6	3	3	2	6	-	6	-
15-17 Yrs. Old	**12**	1	-	1	1	-	-	1	-	-	8	-
Infant Subtotal 2011-2014	**193**	62	19	14	2	5	22	10	7	30	15	7
Infant Age Group**												
0 to 3 months	**108**	30	12	1	1	2	11	5	6	24	12	4
4 to 6 months	**31**	13	3	-	1	2	4	2	-	4	1	1
7 to 11 months	**54**	19	4	13	-	1	7	3	1	2	2	2

** Due to small cell sizes, detailed data on race and ethnicity for Native Americans and Asian/Pacific Islanders has been redacted to maintain confidentiality pursuent to Welfare and Institutions Code 10850.4(e)(1)(A).*

V. 2010-2014 Child Fatalities CWS History Over Time

Characteristic	Total	2010	2011	2012	2013	2014
	n		n	n	n	n
Total	**415**		**119**	**111**	**97**	**88**
Any CW History*						
No	**104**		27	31	26	20
Yes	**311**		92	80	71	68
As adult	**188**		63	45	43	37
As minor	**123**		29	35	28	31
CW History within 5 years of Critical Incident						
No	**167**		43	47	40	37
Yes	**248**		76	64	57	51
As adult	**239**		72	61	56	50
As minor	**9**		4	3	1	1
CWS History within 1 year of Critical Incident						
No	**272**		82	81	61	48
Yes	**143**		37	30	36	40
As adult	**143**		37	30	36	40
As minor	**-**		-	-	-	-
Number of Prior Referrals						
None	**176**		47	50	41	38
1	**84**		29	22	18	15
2-5	**117**		36	30	29	22
6 or more	**38**		7	9	9	13
Time between Referral and Critical Incident						
0 to <6 Months	**118**		31	26	30	31
6 to <12 Months	**25**		6	4	6	9
12 to<18 Months	**26**		9	11	4	2
18 to <24 Months	**25**		10	8	5	2
2 Years to <3 years	**18**		5	4	6	3
3 Years to <5 years	**27**		11	8	5	3
N/A/Missing	**176**		47	50	41	38
Most Recent Allegation Type						
Abuse	**59**		23	13	15	8
Neglect	**131**		35	40	27	29

Characteristic	Total	2010	2011	2012	2013	2014
Abuse & Neglect	**41**		13	8	12	8
Other	**8**		1	-	2	5
Missing	**176**		47	50	41	38
Most Recent Allegation Disposition						
Substantiated	**74**		27	21	13	13
Inconclusive	**45**		10	10	13	12
Unfounded	**70**		21	20	17	12
Evaluated Out	**50**		14	10	13	13
Missing	**176**		47	50	41	38
Fatalities with CWS Case History	**128**	23	28	26	21	30
Case Service Component at Critical Incident						
Not current client (prior CWS history) *	**35**	-	10	10	5	10
Open ER Referral at CI	**52**	11	10	9	9	13
In Home Receiving Services	**27**	8	4	5	6	4
Out-of-Home Receiving Services	**13**	4	3	2	1	3
Other	**1**	-	1	-	-	-

*Information on prior CWS History was not collected in 2010

VI 2010-2014 Child Fatalities - Detailed Child Welfare History by Child Demographics

			CWS Ever			CWS within 1 year	
Characteristic	**Total**		**No**	**Yes**		**No**	**Yes**
	n		**n**	**n**		**n**	**n**
Total	**415**		**104**	**311**		**272**	**143**
Sex							
Female	**173**		43	130		119	54
Male	**242**		61	181		153	89
Race / Ethnicity							
Black	**79**		11	68		50	29
Hispanic	**162**		51	111		116	46
White	**90**		22	68		48	42
Asian/Pacific Islander	**12**		4	8		11	1
Native American	**1**		-	1		1	-
Multi-Race	**39**		2	37		22	17
Not Documented	**3**		1	2		2	1
Missing	**29**		13	16		22	7
Age Group							
<1 Yr. Old	**193**		45	148		128	65
1-4 Yrs. Old	**138**		39	99		88	50
5-9 Yrs. Old	**44**		11	33		29	15
10-14 Yrs. Old	**28**		7	21		20	8
15-17 Yrs. Old	**12**		2	10		7	5
Age Group (1-4 yr. breakout) *							
<1 Yr. Old	**193**		45	148		128	65
1 Yrs. Old	**57**		22	35		44	13
2 Yrs. Old	**44**		7	37		21	23
3 Yrs. Old	**18**		2	16		8	10
4 Yrs. Old	**19**		8	11		15	4
5-9 Yrs. Old	**44**		11	33		29	15
10-14 Yrs. Old	**28**		7	21		20	8
15-17 Yrs. Old	**12**		2	10		7	5
Infant Subtotal 2011-2014	**193**		45	148		128	65
Infant Age Group*							
Newborn to 3 months	**108**		25	83		72	36
4 to 6 months	**31**		6	25		20	11
7 to 11 months	**54**		14	40		36	18

VII. 2010-2014 Child Fatalities - Primary Individual Responsible by Characteristics

Characteristic	Total	Bio Parents together	Bio Mother only	Bio Father only	Bio Mother & Sig Other	F Sig Other / Step Parent	M Sig Other / Step Parent	Other Related F	Other Related M	Other Unrelated F	Other Unrelated M	Adopt Mother	Adopt Father	Foster Parent M/F	Unknown
Total	**543**	**91**	**169**	**123**	**13**	**4**	**54**	**11**	**8**	**8**	**11**	**3**	**1**	**8**	**39**
Sex															
Female	**235**	38	87	47	5	3	17	5	1	4	2	2	1	6	17
Male	**308**	53	82	76	8	1	37	6	7	4	9	1	-	2	22
Race / Ethnicity*															
Black	**108**	16	33	20	2	2	17	3	1	1	1	1	1	1	9
Hispanic	**218**	43	63	54	7	-	20	4	2	4	5	-	-	3	13
White	**119**	16	38	33	4	-	9	-	3	2	4	-	-	2	8
Asian/Pacific Islander	**16**	2	3	5	-	1	2	-	-	-	-	1	-	1	1
Native American	**2**	-	1	1	-	-	-	-	-	-	-	-	-	-	-
Multi-Race	**39**	7	16	6	-	1	2	1	1	-	1	1	-	1	2
Other	**3**	-	2	-	-	-	1	-	-	-	-	-	-	-	-
Not Documented	**38**	7	13	4	-	-	3	3	1	1	-	-	-	-	6
Age Group															
<1 Yr. Old	**246**	64	84	55	2	1	8	1	4	1	3	-	-	5	18
1-4 Yrs. Old	**191**	16	59	34	8	2	35	8	1	5	7	1	-	2	13
5-9 Yrs. Old	**55**	6	17	16	1	-	7	2	1	2	-	-	1	-	2
10-14 Yrs. Old	**34**	2	6	13	2	1	4	-	-	-	1	2	-	-	3
15-17 Yrs. Old	**17**	3	3	5	-	-	-	-	2	-	-	-	-	1	3
Subtotal 2011-2014**	**415**	76	135	91	9	2	46	8	7	8	10	3		4	16
Age Group (1-4 yr. breakout) **															
<1 Yr. Old	**193**	51	73	38	1	1	7	1	4	1	3	-		3	10
1 Yrs. Old	**57**	7	13	14	2	-	12	1	-	4	1	1		-	2
2 Yrs. Old	**44**	6	11	3	2	-	12	3	1	1	4	-		-	1

Characteristic	Total	Bio Parents together	Bio Mother only	Bio Father only	Bio Mother & Sig Other	F Sig Other / Step Parent	M Sig Other / Step Parent	Other Related F	Other Related M	Other Unrelated F	Other Unrelated M	Adopt Mother	Adopt Father	Foster Parent M/F	Unknown
3 Yrs. Old	**18**	1	7	4	1	-	3	1	-	-	1	-		-	-
4 Yrs. Old	**19**	-	9	3	1	1	4	1	-	-	-	-		-	-
5-9 Yrs. Old	**44**	6	15	15	1	-	4	1	-	2	-	-		-	-
10-14 Yrs. Old	**28**	2	6	10	1	-	4	-	-	-	1	2		-	2
15-17 Yrs. Old	**12**	3	1	4	-	-	-	-	2	-	-	-		1	1
Infant Subtotal 2011-2014	**193**	51	73	38	1	1	7	1	4	1	3	-		3	10
Infant Age Group**															
0 to 3 months	**108**	39	45	14	1	1	3	-	-	-	1			1	3
4 to 6 months	**31**	5	4	13	-	-	1	-	4	-	-			1	3
7 to 11 months	**54**	7	24	11	-	-	3	1	-	1	2			1	4
Primary Individual Responsible #2 Relation to Child Victim***															
None	**519**	91	168	121	-	4	53	11	8	8	10	2	-	4	39
Related (F)	**1**	-	-	-	-	-	-	-	-	-	-	-	1	-	-
Related (M)	**2**	-	1	-	-	-	-	-	-	-	-	1	-	-	-
Unrelated (F)	**3**	-	-	2	-	-	-	-	-	-	1	-	-	-	-
Unrelated (M)	**14**	-	-	-	13	-	-	-	-	-	-	-	-	1	-
Other	**4**	-	-	-	-	-	1	-	-	-	-	-	-	3	-
Primary Individual(s) Responsible Age****															
<16 years old	**1**	-	-	-	-	-	-	-	-	-	-	-	-	-	1
16-20 years old	**57**	6	25	7	4	1	8	1	1	2	-	-	-	-	2
21-23 years old	**88**	18	24	18	3	1	16	-	2	3	2	-	-	1	-
24-26 years old	**92**	13	38	18	1	1	13	-	-	-	7	-	-	1	-
27-30 years old	**90**	22	31	24	3	-	7	-	1	1	1	-	-	-	-

Characteristic	Total	Bio Parents together	Bio Mother only	Bio Father only	Bio Mother & Sig Other	F Sig Other / Step Parent	M Sig Other / Step Parent	Other Related F	Other Related M	Other Unrelated F	Other Unrelated M	Adopt Mother	Adopt Father	Foster Parent M/F	Unknown
31-35 years old	**70**	15	26	18	1	-	6	-	-	1	1	-	-	2	-
36-40 years old	**39**	9	12	11	1	-	2	2	-	-	-	-	-	2	-
41-45 years old	**26**	3	9	8	-	1	1	-	1	1	-	2	-	-	-
46-60 years old	**27**	3	4	14	-	-	-	4	-	-	-	-	1	1	-
60+ years old	**3**	-	-	-	-	-	-	1	-	-	-	1	-	1	-
Missing	**50**	2	-	5	-	-	1	3	3	-	-	-	-	-	36
Primary Individual Responsible #1 Race/Ethnicity (11-14) ***															
Black	**80**	11	26	19	1	2	15	-	1	2	1	1		1	-
Hispanic	**161**	31	49	34	7	-	22	5	2	4	5	1		1	-
White	**98**	19	35	25	1	-	7	2	1	1	4	-		2	1
Asian/Pacific Islander	**9**	2	6	1	-	-	-	-	-	-	-	-		-	-
Native American	**2**	-	1	1	-	-	-	-	-	-	-	-		-	-
Multi-Race	**15**	6	3	3	-	-	1	-	-	-	-	1		-	1
Other	**8**	-	5	-	-	-	1	-	-	-	-	-		-	2
Missing	**42**	7	10	8	-	-	-	1	3	1	-	-		-	12
Fatality Location															
Home	**532**	90	169	123	13	4	54	11	8	8	10	3	1	-	38
Foster Care	**11**	1	-	-	-	-	-	-	-	-	1	-	-	8	1
Cause of Fatality															
Blunt Force Trauma	**173**	26	18	46	7	3	33	2	4	4	8	2	1	5	14
Abusive Head Trauma / SBS	**36**	11	2	10	-	-	8	1	-	-	1	-	-	2	1
Medical Neglect	**25**	6	11	4	-	-	-	1	-	-	-	1	-	-	2
Ingested Substance	**18**	2	12	-	-	-	1	-	-	-	1	-	-	1	1
Malnourishment	**6**	3	3	-	-	-	-	-	-	-	-	-	-	-	-
Asphyxiation	**42**	8	14	11	-	-	4	-	-	1	1	-	-	-	3

Characteristic	Total	Bio Parents together	Bio Mother only	Bio Father only	Bio Mother & Sig Other	F Sig Other / Step Parent	M Sig Other / Step Parent	Other Related F	Other Related M	Other Unrelated F	Other Unrelated M	Adopt Mother	Adopt Father	Foster Parent M/F	Unknown
Sleep Related	**40**	13	18	5	-	1	-	-	-	-	-	-	-	-	3
Drowning	**63**	7	38	7	-	-	1	5	1	3	-	-	-	-	1
Maternal Drug Use	**6**	-	6	-	-	-	-	-	-	-	-	-	-	-	-
Gunshot	**30**	2	3	20	-	-	1	1	1	-	-	-	-	-	2
Stabbing	**20**	-	8	7	-	-	3	-	1	-	-	-	-	-	1
Suicide	**4**	1	1	1	-	-	-	-	-	-	-	-	-	-	1
Vehicular Negligence/DUI	**35**	3	14	12	3	-	2	-	1	-	-	-	-	-	-
Burns/Fire	**14**	3	9	-	-	-	-	1	-	-	-	-	-	-	1
Victim Abandoned /Hypothermia	**8**	1	5	-	-	-	-	-	-	-	-	-	-	-	2
Mauled	**1**	-	1	-	-	-	-	-	-	-	-	-	-	-	-
Other	**2**	-	-	-	1	-	-	-	-	-	-	-	-	-	1
Undetermined	**15**	4	4	-	1	-	-	-	-	-	-	-	-	-	6
Missing	**5**	1	2	-	1	-	1	-	-	-	-	-	-	-	-
Allegation of Critical Incident															
None	**7**	-	-	-	-	-	-	-	-	-	-	-	-	-	7
Abuse	**175**	15	25	54	3	3	37	4	6	4	9	1	-	5	9
Neglect	**264**	51	122	41	6	1	7	6	2	4	2	1	-	2	19
Abuse & Neglect	**94**	25	22	28	4	-	10	1	-	-	-	1	1	1	1
Other	**3**	-	-	-	-	-	-	-	-	-	-	-	-	-	3

Appendices – Child Near Fatalities

VIII. 2010-2014 Child Population, Child Near Fatalities and Rate per 100,000

	Population					Child Near Fatalities					Near Fatality Rate				
	2010	2011	2012	2013	2014	2010	2011	2012	2013	2014	2010	2011	2012	2013	2014
Total	**9,273,754**	**9,203,420**	**9,149,419**	**9,104,860**	**9,097,971**	**121**	**135**	**130**	**119**	**103**	**1.30**	**1.47**	**1.42**	**1.31**	**1.13**
Age Group															
<1 Yr. Old	493,399	506,768	495,240	497,410	502,818	67	67	60	63	59	13.58	13.22	12.12	12.67	11.73
1-4 Yrs. Old	2,033,169	2,013,325	2,005,213	1,989,392	1,998,347	44	43	53	34	27	2.16	2.14	2.64	1.71	1.35
5-9 Yrs. Old	2,504,035	2,501,508	2,524,358	2,537,336	2,536,409	3	15	8	10	10	0.12	0.60	0.32	0.39	0.39
10-14 Yrs. Old	2,583,627	2,553,685	2,529,056	2,515,768	2,514,558	6	8	2	9	5	0.23	0.31	0.08	0.36	0.20
15-17 Yrs. Old	1,659,524	1,628,134	1,595,552	1,564,954	1,545,839	1	2	7	3	2	0.06	0.12	0.44	0.19	0.13
Sex															
Female	4,528,816	4,497,506	4,473,282	4,453,134	4,451,179	51	49	57	51	43	1.13	1.09	1.27	1.15	0.97
Male	4,744,938	4,705,914	4,676,137	4,651,726	4,646,792	70	86	73	68	60	1.48	1.83	1.56	1.46	1.29
Race/Ethnicity*															
Black	527,695	516,416	503,885	493,035	487,981	28	23	24	25	18	5.31	4.45	4.76	5.07	3.69
Hispanic	4,747,973	4,722,627	4,697,887	4,669,624	4,675,027	40	52	59	42	49	0.84	1.10	1.26	0.90	1.05
White	2,560,676	2,526,028	2,505,391	2,486,123	2,465,851	38	32	31	30	19	1.48	1.27	1.24	1.21	0.77
Asian/P.I.	1,006,311	1,001,196	999,957	1,008,249	1,017,657	3	7	2	6	2	0.30	0.70	0.20	0.60	0.20
Nat American	37,975	37,148	36,289	35,620	35,119	0	1	2	1	0	-	2.69	5.51	2.81	-
Multi-Race	393,124	400,005	406,010	412,209	416,336		20	9	5	12		5.00	2.22	1.21	2.88

*Children with Other or Not Documented Race/Ethnicity are excluded

*Multi-Race category was not available in 2010

IX. 2010-2014 Child Near Fatalities - Characteristics by Year

Category	TOTAL	2010	2011	2012	2013	2014
	n	n	n	n	n	n
Total	**608**	**121**	**135**	**130**	**119**	**103**
Sex						
Female	251	51	49	57	51	43
Male	357	70	86	73	68	60
Race / Ethnicity*						
Black	118	28	23	24	25	18
Hispanic	242	40	52	59	42	49
White	149	38	32	31	29	19
Asian/Pacific Islander	20	3	7	2	6	2
Native American	4	0	1	2	1	-
Multi-Race	46	0	20	9	5	12
Other	4	4	0	0	0	0
Not Documented	25	8	0	3	10	3
Age Group						
<1 Yr. Old	316	67	67	60	63	59
1-4 Yrs. Old	201	44	43	53	34	27
5-9 Yrs. Old	46	3	15	8	10	10
10-14 Yrs. Old	30	6	8	2	9	5
15-17 Yrs. Old	15	1	2	7	3	2
Subtotal 2011-2014*	487		135	130	119	103
Age Group (1-4 yr. breakout) *						
<1 Yr. Old	249		67	60	63	59
1 Yrs. Old	62		17	20	13	12
2 Yrs. Old	40		8	14	8	10
3 Yrs. Old	28		9	9	7	3
4 Yrs. Old	27		9	10	6	2
5-9 Yrs. Old	43		15	8	10	10
10-14 Yrs. Old	24		8	2	9	5
15-17 Yrs. Old	14		2	7	3	2
Infant Subtotal 2011-2014	249		67	60	63	59
Infant Age Group*						
0 to 3 months	133		36	29	35	33
4 to 6 months	58		19	15	11	13
7 to 11 months	58		12	16	17	13
Primary Individual(s) Responsible Relation to Child Victim**						
Bio Parents (together)	113	25	32	24	7	25
Bio Mother (only)	149	28	42	37	9	33
Bio Father (only)	107	25	27	29	7	19
Bio Mother & Sig Other	17	3	3	7	2	2
Sig Other/Step Parent F	3	0	0	2	0	1
Sig Other/Step Parent M	35	5	9	9	2	10

Category	TOTAL	2010	2011	2012	2013	2014
Other Related F	15	4	3	6	2	0
Other Related M	3	0	2	0	0	1
Other Unrelated F	8	0	2	5	1	0
Other Unrelated M	9	0	2	1	2	4
Adopt Mother	3	0	3	0	0	0
Adopt Father	1	1	0	0	0	0
Foster Parent M/F	8	3	3	0	1	1
Other	10	2	1	0	0	7
Missing	127	25	6	10	86	0
Primary Individual Responsible #2 Relation to Child Victim* **						
None	576	116	126	120	117	97
Related (F)	2	1	1	0	0	0
Related (M)	5	0	2	3	0	0
Unrelated (F)	5	0	2	0	0	3
Unrelated (M)	17	3	3	7	2	2
Other	3	1	1	0	0	1
Primary Individual(s) Responsible Age** **						
<16 years old	3	0	1	0	1	1
16-20 years old	71	16	23	16	3	13
21-23 years old	81	17	16	26	6	16
24-26 years old	74	12	24	15	6	17
27-30 years old	67	13	15	20	4	15
31-35 years old	80	18	22	17	8	15
36-40 years old	39	8	9	11	0	11
41-45 years old	19	5	5	5	0	4
46-60 years old	24	5	7	7	3	2
60+ years old	7	1	2	2	1	1
Unknown	143	26	11	11	87	8
Primary Individual Responsible #1 Race/Ethnicity*** **						
Black	46		29			17
Hispanic	95		50			45
White	51		33			18
Asian/Pacific Islander	8		5			3
Native American	8		0			8
Multi-Race	1		1			0
Other	278		17			12
Near Fatality Location						
Home	588	117	128	128	114	101
Foster Care	20	4	7	2	5	2
Finding Incident Due to						
Crime	95	19	39			37
Suicide Attempt	1	0	0			1
Non-Accidental	145	50	54			41
Undetermined	6	2	3			1
Other	111	50	39			22
Missing	1	0	0			1
Cause of Near Fatality						
Blunt Force Trauma	166	62	36	28	7	33

Category	TOTAL	2010	2011	2012	2013	2014
Abusive Head Trauma / SBS	165	21	43	51	14	36
Medical Neglect	50	5	21	10	5	9
Ingested Substance	32	7	10	6	3	6
Malnourishment	3	2	0	0	1	0
Asphyxiation	3	0	0	2	0	1
Sleep Related	0	0	0	0	0	0
Near Drowning	31	12	5	10	0	4
Maternal Drug Use	4	0	0	1	1	2
Gunshot	4	0	0	3	0	1
Stabbing	3	2	0	0	0	1
Suicide Attempt	4	1	0	1	0	2
Vehicular Negligence/DUI	35	4	10	10	5	6
Burns/Fire	17	4	6	6	0	1
Victim Abandoned /Hypothermia	2	1	0	0	0	1
Mauled	0	0	0	0	0	0
Other	3	0	1	2	0	0
Undetermined	3	0	3	0	0	0
Missing	83	0	0	0	83	0
Allegation of Critical Incident						
None	87	3	1	0	83	0
Abuse	173	55	38	38	8	34
Neglect	214	39	55	58	20	42
Abuse & Neglect	134	24	41	34	8	27

** Multi-Race category and Detailed Age information was not available in 2010*

*** Bio parents together, Bio Mother w/Male Sig Other, & Bio Father w/Female Sig Other categories are a combination of the Primary Individual Responsible #1 and Primary Individual Responsible #2 Relationship to Child*

****Bio parents together, Bio Mother w/Male Sig Other, & Bio Father w/Female Sig Other are coded as None since they are represented elsewhere*

***** When two individuals were listed as responsible (Primary Individual(s) Responsible Relation to Child Victim) the age of youngest was utilized.*

******Race/Ethnicity data not available for 2010*

X. 2010-2014 Child Near Fatalities – Demographic Characteristics of Infant Victims

	TOTAL					2010					2011			
	Total	**0-3 month**	**4-6 month**	**7-11 month**		**Total**	**0-3 month**	**4-6 month**	**7-11 month**		**Total**	**0-3 month**	**4-6 month**	**7-11 month**
Total	**249**	**133**	**58**	**58**					**16**		**67**	**36**	**19**	**12**
Sex														
Female	**106**	**61**	**23**	**22**					3		21	11	5	5
Male	**143**	**72**	**35**	**36**					13		46	25	14	7
Race / Ethnicity														
Black	**42**	**21**	**12**	**9**					3		11	5	6	0
Hispanic	**102**	**50**	**24**	**28**					7		27	11	9	7
White	**60**	**36**	**11**	**13**					6		12	9	1	2
Asian/Pacific Islander	**7**	**1**	**2**	**4**					0		4	1	0	3
Native American	**1**	**1**	**0**	**0**					0		0	0	0	0
Multi-Race	**27**	**19**	**6**	**2**					0		13	10	3	0
Missing	**10**	**5**	**3**	**2**					0		0	0	0	0

	2012					2013					2014			
	Total	**0-3 month**	**4-6 month**	**7-11 month**		**Total**	**0-3 month**	**4-6 month**	**7-11 month**		**Total**	**0-3 month**	**4-6 month**	**7-11 month**
Total	**60**	**29**	**15**	**16**		**63**	**35**	**11**	**17**		**59**	**33**	**13**	**13**
Sex														
Female	23	11	9	3		32	21	4	7		30	18	5	7
Male	37	18	6	13		31	14	7	10		29	15	8	6
Race / Ethnicity														
Black	11	5	3	3		11	5	3	3		9	6	0	3
Hispanic	23	10	6	7		21	12	3	6		31	17	6	8
White	18	10	2	6		19	13	1	5		11	4	7	0
Asian/Pacific Islander	0	0	0	0		2	0	2	0		1	0	0	1
Native American	1	1	0	0		0	0	0	0		0	0	0	0
Multi-Race	5	2	3	0		3	2	0	1		6	5	0	1
Missing	2	1	1	0		7	3	2	2		1	1	0	0

*Detailed age data not available for 2010

XI. 2010-2014 Child Near Fatalities - Cause by Victim Demographics

Characteristic	Total	Blunt Force Trauma	Abusive Head Trauma / SBS	Near Drowning	Vehicular Negligence	Stabbing	Asphyxiation	Ingested Substance	Medical Neglect	Other	Missing
	n	n	n	n	n	n	n	n	n	n	n
Total	608	166	165	31	35	3	3	32	50	37	86
Sex											
Female	251	61	63	17	14	-	2	16	25	16	37
Male	357	105	102	14	21	3	1	16	25	21	49
Race / Ethnicity											
Black	118	36	18	5	10	1	-	11	10	10	17
Hispanic	242	60	76	8	14	2	2	10	22	15	33
White	150	43	38	14	6	-	1	9	12	7	20
Asian/Pacific Islander	20	*	*	*	*	*	*	*	*	*	*
Native American	4	*	*	*	*	*	*	*	*	*	*
Multi-Race	46	15	17	2	3	-	-	1	5	2	1
Other/Not Documented	28	7	8	-	2	-	-	-	-	2	9
Age Group											
<1 Yr. Old	316	88	126	11	2	-	2	11	18	10	48
1-4 Yrs. Old	201	63	37	18	12	1	1	18	11	17	23
5-9 Yrs. Old	46	10	2	2	16	1	-	-	6	3	6
10-14 Yrs. Old	30	4	-	-	3	1	-	-	11	5	6
15-17 Yrs. Old	15	1	-	-	2	-	-	3	4	2	3
Subtotal 2011-2014**	487	104	144	19	31	1	3	25	45	29	86
Age Group (1-4 yr. breakout) *											
<1 Yr. Old	249	50	108	7	2	-	2	9	16	7	48
1 Yrs. Old	62	12	17	7	2	-	-	7	4	4	9
2 Yrs. Old	40	14	8	1	3	-	-	5	1	3	5
3 Yrs. Old	28	7	4	2	2	-	-	-	3	4	6

Characteristic	Total	Blunt Force Trauma	Abusive Head Trauma / SBS	Near Drowning	Vehicular Negligence	Stabbing	Asphyxiation	Ingested Substance	Medical Neglect	Other	Missing
4 Yrs. Old	27	7	5	-	4	-	1	2	2	3	3
5-9 Yrs. Old	43	10	2	2	14	1	-	-	6	2	6
10-14 Yrs. Old	24	3	-	-	2	-	-	-	9	4	6
15-17 Yrs. Old	14	1	-	-	2	-	-	2	4	2	3
Infant Subtotal 2014	249	50	108	7	2		2	9	16	7	48
Infant Age Group*											
Newborn to 3 months	133	30	56	-	-		1	2	13	6	25
4 to 6 months	58	9	31	1	1		1	2	2	-	11
7 to 11 months	58	11	21	6	1		-	5	1	1	12

*** Due to small cell sizes, detailed data on race and ethnicity for Native Americans and Asian/Pacific Islanders has been redacted to maintain confidentiality pursuent to Welfare and Institutions Code 10850.45(f)(1).*

XII. 2010-2014 Child Near Fatalities – Child Welfare History Over Time

Characteristic	Total	2010	2011	2012	2013	2014
	n		n	n	n	n
Total	**487**		**135**	**130**	**119**	**103**
Any CW History*						
No	228		41	56	97	34
Yes	259		94	74	22	69
As adult	171		54	65	20	32
As minor	88		40	9	2	37
CW History within 5 years of Critical Incident						
No	264		64	56	97	47
Yes	223		71	74	22	56
As adult	206		71	65	20	50
As minor	17		-	9	2	6
CWS History within 1 year of Critical Incident						
No	159		89			70
Yes	79		46			33
As adult	79		46			33
As minor	-		-			-
Total	**487**		**135**	**130**	**119**	**103**
Number of Prior Referrals						
None	278		65	61	99	53
1	64		21	24	7	12
2-5	113		38	37	8	30
6 or more	32		11	8	5	8
Time between Referral and Critical Incident						
0 to <6 Months	58		36			22
6 to <12 Months	21		10			11
12 to<18 Months	12		8			4
18 to <24 Months	8		4			4
2 Years to < 3 Years	9		6			3
3 Years to < 5 Years	12		6			6
N/A/Missing	118		65			53
Most Recent Allegation Type						
Abuse	21		14			7
Neglect	75		42			33
Abuse & Neglect	21		14			7
Other	1		-			1

Characteristic	Total	2010	2011	2012	2013	2014
Missing	120		65			55
Most Recent Allegation Disposition						
Substantiated	44		27			17
Inconclusive	24		11			13
Unfounded	25		19			6
Evaluated						
Out/Assessment Only	25		13			12
Missing	120		65			55
Fatalities with CWS Case History	79	13	37			29
Case Service Component at Critical Incident						
Not current client (prior CWS history) *	24		12			12
Open ER Referral at CI	31	7	15			9
In Home Receiving Services	15	6	3			6
Out-of-Home Receiving Services	6		4			2
Other	3		3			

*Detailed data on child welfare history was not collected in 2010

*Information on CWS History within one year and detailed data on prior referrals was not collected in 2012 and 2013

XIII. 2010-2014 Child Near Fatalities - Detailed Child Welfare History by Child Demographics

			CWS Ever			CWS within 1 year (2011 & 2014 Only)	
Characteristic	**Total**		**No**	**Yes**	**Total**	**No**	**Yes**
	n		**n**	**n**	**n**	**n**	**n**
Total	487		228	259	238	159	79
Sex							
Female	200		97	103	92	63	29
Male	287		131	156	146	96	50
Race / Ethnicity							
Black	90		37	53	41	26	15
Hispanic	202		88	114	101	69	32
White	112		61	51	51	31	20
Asian/Pacific Islander	17		12	5	9	6	3
Native American	4		2	2	1	-	1
Multi-Race	46		15	31	32	25	7
Not Documented	16		13	3	3	2	1
Missing							
Age Group							
<1 Yr. Old	249		130	119	126	88	38
1-4 Yrs. Old	157		71	86	70	44	26
5-9 Yrs. Old	43		15	28	25	17	8
10-14 Yrs. Old	24		8	16	13	6	7
15-17 Yrs. Old	14		4	10	4	4	-
Age Group (1-4 yr. breakout) *							
<1 Yr. Old	249		130	119	126	88	38
1 Yrs. Old	62		35	27	29	20	9
2 Yrs. Old	40		16	24	18	12	6
3 Yrs. Old	28		12	16	12	6	6
4 Yrs. Old	27		8	19	11	6	5
5-9 Yrs. Old	43		15	28	25	17	8
10-14 Yrs. Old	24		8	16	13	6	7
15-17 Yrs. Old	14		4	10	4	4	-
Infant Subtotal 2014	249		130	119	126	88	38
Infant Age Group*							
Newborn to 3 months	133		69	64	69	48	21
4 to 6 months	58		31	27	32	25	7
7 to 11 months	58		30	28	25	15	10

XIV. 2010-2014 Child Near Fatalities - Primary Individual Responsible by Child Victim Demographics

Characteristic	Total	Bio Parents together	Bio Mother only	Bio Father only	Bio Mother & Sig Other	F Sig Other / Step Parent	M Sig Other / Step Parent	Other Related F	Other Related M	Other Unrelated F	Other Unrelated M	Adopt Mother	Adopt Father	Foster M/F	Missing
	n	n	n	n	n	n	n	n	n	n	n	n	n	n	n
Total	608	113	149	107	17	3	35	15	3	8	9	3	1	8	137
Sex															
Female	251	52	58	45	9	1	13	8	1	2	3	1	1	1	56
Male	357	61	91	62	8	2	22	7	2	6	6	2	-	7	81
Race / Ethnicity*															
Black	118	16	35	18	7	1	7	4	-	1	1	-	1	3	24
Hispanic	242	50	61	40	7	-	8	9	3	5	3	2	-	-	54
White	150	31	33	27	1	2	11	1	-	1	3	1	-	4	35
Asian/Pacific Islander	20	2	5	4	-	-	1	-	-	-	-	-	-	-	8
Native American	4	1	-	1	-	-	-	-	-	-	-	-	-	1	1
Multi-Race	46	10	15	10	2	-	6	-	-	1	-	-	-	-	2
Other	4	1	-	1	-	-	-	-	-	-	-	-	-	-	2
Not Documented	24	2	-	6	-	-	2	1	-	-	2	-	-	-	11
Age Group															
<1 Yr. Old	316	71	63	76	7	-	8	2	-	6	1	-	-	1	81
1-4 Yrs. Old	201	32	53	18	9	2	24	10	2	2	5	-	-	5	39
5-9 Yrs. Old	46	3	18	6	-	1	3	2	-	-	1	3	-	1	8
10-14 Yrs. Old	30	4	12	4	-	-	-	-	1	-	2	-	1	-	6
15-17 Yrs. Old	15	3	3	3	1	-	-	1	-	-	-	-	-	1	3
Subtotal 2011-2014**	487	88	121	82		3	30	11	3	8	9	3	5	8	116
Age Group (1-4 yr. breakout) **															
<1 Yr. Old	249	56	51	55		-	8	1	-	6	1	-	1	6	64
1 Yrs. Old	62	14	17	5		-	6	3	-	1	3	-	2	-	-
2 Yrs. Old	40	4	11	2		1	3	4	2	-	2	-	-	-	11

Characteristic	Total	Bio Parents together	Bio Mother only	Bio Father only	Bio Mother & Sig Other	F Sig Other / Step Parent	M Sig Other / Step Parent	Other Related F	Other Related M	Other Unrelated F	Other Unrelated M	Adopt Mother	Adopt Father	Foster M/F	Missing
3 Yrs. Old	28	1	5	5		-	6	1	-	1	-	-	1	-	8
4 Yrs. Old	27	3	9	4		1	4	-	-	-	-	-	-	-	6
5-9 Yrs. Old	43	3	16	6		1	3	1	-	-	1	3	1	2	-
10-14 Yrs. Old	24	4	9	2		-	-	-	1	-	2	-	-	-	-
15-17 Yrs. Old	14	3	3	3		-	-	1	-	-	-	-	-	-	4
Infant Subtotal 2011-2014	249	56	51	55		-	8	1	-	6	1	-	1	6	64
Infant Age Group**															
0 to 3 months	133	37	26	35	2		2	-		3	-			1	27
4 to 6 months	58	10	7	13	2		3	-		2	-			-	21
7 to 11 months	58	9	18	7	-		3	1		1	1			-	18
	249	56	51	55		-	8	1	-	6	1	-	1	6	64
Primary Individual(s) Responsible Age****															
<16 years old	3	-	1	1	-	-	-	-	-	-	-	-	-	-	-
16-20 years old	71	32	19	14	2	1	3	-	-	-	-	-	-	-	-
21-23 years old	81	15	25	24	4	1	10	2	-	-	-	-	-	-	-
24-26 years old	74	10	22	19	7	1	11	1	-	1	1	-	-	1	-
27-30 years old	67	20	24	10	1	-	6	3	-	2	-	1	-	-	-
31-35 years old	80	17	31	20	1	-	3	-	1	3	1	1	-	1	-
36-40 years old	39	11	15	10	1	-	-	-	-	-	1	-	-	-	-
41-45 years old	19	5	8	3	-	-	-	-	-	-	1	-	-	2	-
46-60 years old	24	3	4	4	-	-	-	6	1	-	2	1	1	2	-
60+ years old	7	-	-	2	1	-	-	3	-	-	-	-	-	1	-
Missing	143	-	-	-	-	-	2	-	1	2	3	-	-	1	127
PIR #1 Race/Ethnicity (11-14) ***															
Black	46	13	17	8		-	3	1	-	-	1	-	1	-	2

Characteristic	Total	Bio Parents together	Bio Mother only	Bio Father only	Bio Mother & Sig Other	F Sig Other / Step Parent	M Sig Other / Step Parent	Other Related F	Other Related M	Other Unrelated F	Other Unrelated M	Adopt Mother	Adopt Father	Foster M/F	Missing
Hispanic	95	26	31	22		-	8	1	2	-	1	2	-	-	2
White	51	15	15	10		1	3	-	-	1	2	1	1	1	1
Asian/Pacific Islander	8	1	4	3		-	-	-	-	-	-	-	-	-	-
Native American															
Multi-Race	8	1	5	2		-	-	-	-	-	-	-	-	-	-
Other	1	-	1	-		-	-	-	-	-	-	-	-	-	-
Not Documented	278	32	48	37		2	16	9	1	7	5	-	3	7	111
Fatality Location															
Home	588	113	147	106	17	3	35	12	3	7	8	3	1	-	133
Foster Care	20	-	2	1	-	-	-	3	-	1	1	-	-	8	4
Finding Incident Due to															
Crime	95	13	22	28	3	1	14	1	1	1	5	1	-	3	-
Suicide	1	-	1	-	-	-	-	-	-	-	-	-	-	-	-
Non-Accidental	145	41	29	29	4	-	6	2	-	1	1	1	1	2	28
Undetermined	6	1	2	1	1	-	-	-	-	-	-	-	-	-	1
Other	111	27	49	13	-	-	3	4	2	-	-	1	-	2	10
Missing	250	31	46	36	9	2	12	8	-	6	3	-	-	1	96
Cause of Near Fatality															
Blunt Force Trauma	166	33	31	43	9	1	12	3	1	1	3	1	1	2	25
Abusive Head Trauma/SBS	165	39	28	36	2	1	18	3	-	7	2	-	-	2	27
Medical Neglect	50	18	25	4	1	-	-	-	1	-	-	1	-	-	-
Ingested Substance	32	11	11	3	2	-	1	1	-	-	2	-	-	1	-
Malnourishment	3	3	-	-	-	-	-	-	-	-	-	-	-	-	-
Asphyxiation	3	-	2	1	-	-	-	-	-	-	-	-	-	-	-
Sleep Related															
Near Drowning	31	4	17	5	-	-	1	2	-	-	-	-	-	1	1

Characteristic	Total	Bio Parents together	Bio Mother only	Bio Father only	Bio Mother & Sig Other	F Sig Other / Step Parent	M Sig Other / Step Parent	Other Related F	Other Related M	Other Unrelated F	Other Unrelated M	Adopt Mother	Adopt Father	Foster M/F	Missing
Maternal Drug Use	4	-	4	-	-	-	-	-	-	-	-	-	-	-	-
Gunshot	4	-	-	2	-	-	-	1	-	-	1	-	-	-	-
Stabbing	3	-	2	-	-	-	-	-	-	-	1	-	-	-	-
Suicide Attempt	4	1	1	2	-	-	-	-	-	-	-	-	-	-	-
Vehicular Negligence/DUI	35	-	19	9	-	-	2	3	1	-	-	-	-	1	-
Burns/Fire	17	1	5	2	3	1	1	2	-	-	-	1	-	1	-
Victim Abandoned /Hypothermia	2	-	1	-	-	-	-	-	-	-	-	-	-	-	1
Mauled															
Other	3	1	2	-	-	-	-	-	-	-	-	-	-	-	-
Undetermined	3	2	1	-	-	-	-	-	-	-	-	-	-	-	-
Missing	83	-	-	-	-	-	-	-	-	-	-	-	-	-	83
Allegation of Critical Incident															
Abuse	173	29	14	40	5	3	25	4	1	7	3	1	-	1	40
Neglect	214	46	104	32	5	-	3	10	2	1	3	1	-	4	3
Abuse & Neglect	134	38	31	35	7	-	7	1	-	-	2	1	1	3	8
Missing	87	-	-	-	-	-	-	-	-	-	1	-	-	-	86

Appendices – Child Fatalities and Near Fatalities

XV. 2010-2014 Child Critical Incidents, Child Population (0-17) and Rate per 100,000

	Critical Incidents						Child Population (0-17)						Rate per 100,000					
	2010	**2011**	**2012**	**2013**	**2014**	**5 Year Total**	**2010**	**2011**	**2012**	**2013**	**2014**	**5 Year Total**	**2010**	**2011**	**2012**	**2013**	**2014**	**5 Year Total**
Total	**249**	**254**	**241**	**216**	**191**	**1,151**	**9,273,754**	**9,203,420**	**9,149,419**	**9,104,860**	**9,097,971**	**45,829,424**	**2.68**	**2.76**	**2.63**	**2.37**	**2.10**	**2.5**
Age Group																		
<1 Yr. Old	**120**	**125**	**116**	**107**	**94**	**562**	493,399	506,768	495,240	497,410	502,818	**2,495,635**	24.3	24.7	23.4	21.5	18.7	**22.5**
1-4 Yrs. Old	**97**	**78**	**89**	**66**	**62**	**392**	2,033,169	2,013,325	2,005,213	1,989,392	1,998,347	**10,039,446**	4.8	3.9	4.4	3.3	3.1	**3.9**
5-9 Yrs. Old	**14**	**29**	**18**	**22**	**18**	**101**	2,504,035	2,501,508	2,524,358	2,537,336	2,536,409	**12,603,646**	0.6	1.2	0.7	0.9	0.7	**0.8**
10-14 Yrs. Old	**12**	**15**	**8**	**17**	**12**	**64**	2,583,627	2,553,685	2,529,056	2,515,768	2,514,558	**12,696,694**	0.5	0.6	0.3	0.7	0.5	**0.5**
15-17 Yrs. Old	**6**	**7**	**10**	**4**	**5**	**32**	1,659,524	1,628,134	1,595,552	1,564,954	1,545,839	**7,994,003**	0.4	0.4	0.6	0.3	0.3	**0.4**
Sex																		
Female	**113**	**97**	**108**	**90**	**78**	**486**	4,528,816	4,497,506	4,473,282	4,453,134	4,451,179	**22,403,917**	2.5	2.2	2.4	2.0	1.8	**2.2**
Male	**136**	**157**	**133**	**126**	**113**	**665**	4,744,938	4,705,914	4,676,137	4,651,726	4,646,792	**23,425,507**	2.9	3.3	2.8	2.7	2.4	**2.8**
Race/Ethnicity*																		
Black	**57**	**43**	**45**	**49**	**32**	**226**	527,695	516,416	503,885	493,035	487,981	**2,529,012**	10.8	8.3	8.9	9.9	6.6	**8.9**
Hispanic	**96**	**102**	**105**	**79**	**78**	**460**	4,747,973	4,722,627	4,697,887	4,669,624	4,675,027	**23,513,138**	2.0	2.2	2.2	1.7	1.7	**2.0**
White	**67**	**59**	**48**	**54**	**41**	**269**	2,560,676	2,526,028	2,505,391	2,486,123	2,465,851	**12,544,069**	2.6	2.3	1.9	2.2	1.7	**2.1**
Asian/P.I.	**7**	**13**	**6**	**8**	**2**	**36**	1,006,311	1,001,196	999,957	1,008,249	1,017,657	**5,033,370**	0.7	1.3	0.6	0.8	0.2	**0.7**
Nat American	**1**	**1**	**2**	**1**	**1**	**6**	37,975	37,148	36,289	35,620	35,119	**182,151**	2.6	2.7	5.5	2.8	2.8	**3.3**
Multi-Race**	-	**30**	**17**	**12**	**26**	**85**	393,124	400,005	406,010	412,209	416,336	**2,027,684**	-	7.5	4.2	2.9	6.2	**4.2**

** Children with Other or Not Documented or Missing Race/Ethnicity are excluded*

** Multi-Race category was not available in 2010